CANADIAN FEDERATION
OF NURSES UNIONS

Full report

Opening the black box: Unpacking the use of nursing agencies in Canada

Joan Almost, RN, PhD
Professor

September 2024

Canadian Federation of Nurses Unions

About the CFNU

The CFNU is Canada's largest nurses' organization, representing frontline unionized nurses and nursing students in every sector of health care – from home care and long-term care to community and acute care – and advocating on key priorities to strengthen public health care across the country.

Land acknowledgement

From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis and First Nations Peoples that call this land home. The Canadian Federation of Nurses Unions is located on the traditional unceded territory of the Algonquin Anishnaabeg People. As settlers and visitors, we feel it's important to acknowledge the importance of these lands, which we each call home. We do this to reaffirm our commitment and responsibility to improve relationships between nations, to work towards healing the wounds of colonialism and to improve our own understanding of local Indigenous Peoples and their cultures.

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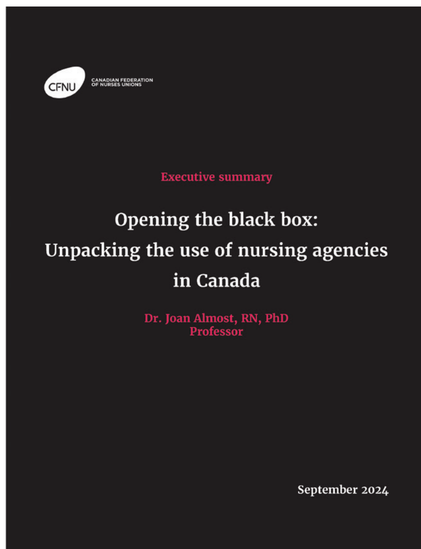

Scan the QR code to read the executive summary of *Opening the black box: Unpacking the use of nursing agencies in Canada.* Available in English and French.

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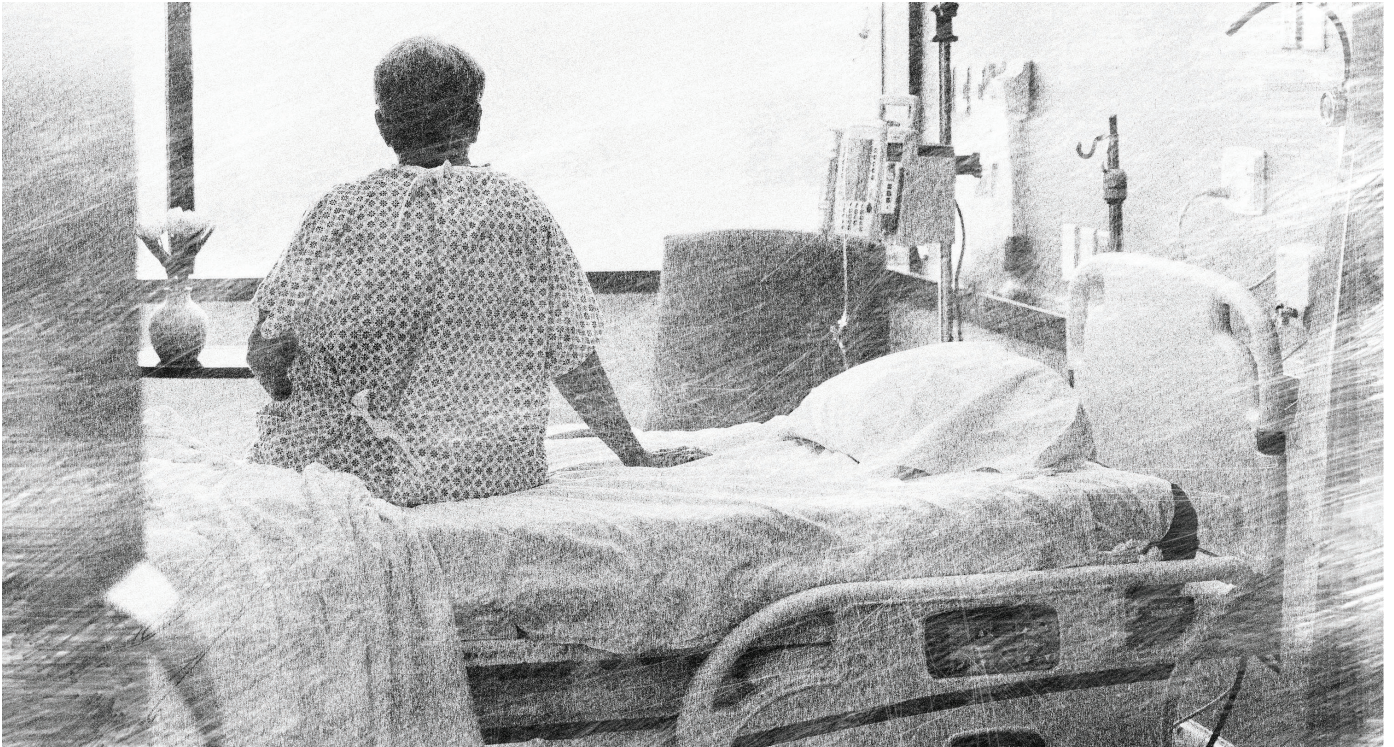
Introduction

A notable trend in Canada during the pandemic was the significant rise in the use of private nursing agencies (“agencies”) by health care facilities to fill critical, short-term staffing needs. This trend has continued with agencies now becoming a bandage for a chronic nursing shortage that has been building for the past two decades. Desperate hospitals, health authorities and long-term care (LTC) homes, already under the strain of several years of COVID-19, have increasingly turned to agencies to fill staffing gaps and limit the number of service cuts resulting in dramatic increases to their operational budgets. Many media articles have painted a stark and alarming picture of public money now being spent on private agencies across the country. Spending which, as a whole, continues to increase across the provinces and territories each year and is ultimately unsustainable for the health care system. However, beyond media articles, publicly available data on the use of agencies are practically nonexistent. Therefore, the Canadian Federation of Nurses Unions (CFNU) commissioned a research study to examine the current landscape on the use of agencies across Canada, including the number of agencies, associated costs, agency hours, and sectors/settings, as well as potential implications for professional practice and the publicly funded health care system. This report examines several research questions outlined below and provides recommendations for moving forward. To ensure a diverse and objective perspective, extensive effort was made to collect data from a variety of primary and secondary sources across Canada. In addition, the author of this report recognizes that nurses are not the only profession who works with agencies or has concerns about the rising costs. Nor are they the only profession currently experiencing significant workforce shortages. While this report focuses only on agencies who hire or arrange contracts for regulated nurses, it is hoped that the information provided can be used as a springboard for future research examining this area with other groups of health care professionals.



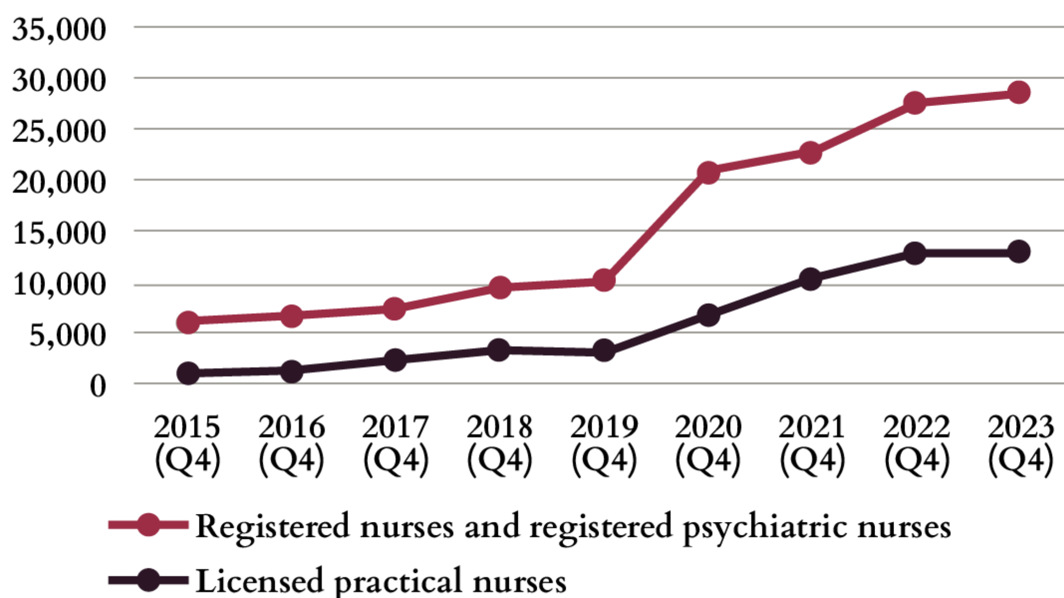
Background

Agencies are for-profit nurse staffing companies that provide what are commonly referred to in Canada as travel, temporary, or agency nurses. The agency hires nurses and arranges contracts with a health care facility typically spanning a few weeks to several months then arranges for nurses to fill those contracts. The agency is paid by the health care facility based on the terms outlined in the contract, and, in turn, the agency pays the nurse. The nurses are often supervised and work under the direction of the health care facility where they are working.

The nurse may be an independent contractor or employee in the context of such a tripartite relationship. The question can arise as to which entity, the agency or the health care facility, constitutes the true employer of the nurse based on who exercises the greatest control over all aspects of their work including the hiring or selection process, discipline, training, evaluation, supervision, and assignment of duties. The degree to which nurses are integrated into the facility's operations and the length of time that the nurse provides services will impact whether the nurse is considered an employee of the facility (Canadian Union of Public Employees, Local 2119 – Perth and Smiths Falls District Hospital, 2024; Young, 2024).

Agencies have been around for decades and have served a necessary role in the delivery of health care services. They have played key roles in the delivery of home care and community services, shoring up hospitals and nursing homes for short-term staffing needs, and providing nurses to health care facilities in remote communities where it is often difficult to attract permanent staff. Agencies were never intended to fill a chronic nationwide full-time nursing staff shortage, and the system cannot continue to accommodate this spending (Kaasalainen, 2023).

Figure 1
Nursing job vacancies in Canada 2015 (Q4) to 2023 (Q4)



(Statistics Canada, 2024a; 2024b)

All designations of nurses in Canada, including registered nurses (RN), licensed practical nurses (LPN) (registered practical nurses in Ontario), registered psychiatric nurses (RPN) and nurse practitioners (NP), have long had the opportunity to work for agencies, however the number was always believed to be low as agency work had downsides with no pension, no benefits and no guaranteed hours. However, over the past decade, nurses have increasingly reported experiences of burnout, moral distress (Royal Society of Canada, 2022) and a desire to leave their jobs or the profession (Statistics Canada, 2023) due to complex intersecting issues, such as worsening work conditions, disrespect, heavy workloads, mandatory overtime, lack of flexibility, and inadequate staffing (Ben-Ahmed & Bourgeault, 2022). A report by the Canadian Institute for Health Information (CIHI) (2023a) revealed that the number of overtime hours worked and sick days taken by nurses across Canada spiked during the COVID-19 pandemic, and this trend continues today (French, 2024; May, 2024). Hospital in-patient units across the country paid for 14.2 million hours of nursing overtime in 2021-2022, a 53% increase over the year before. That's the equivalent of replacing 7,300 full-time nurses with overtime shifts. Sick time, meanwhile, increased by 17% in the same period (CIHI, 2023a) due to the strain on nurses' physical and mental health. Adding to this were government initiatives, such as Bill 124 in Ontario, which was introduced in June 2019 to limit public-sector wage hikes, including nurses, to 1% per year for three years (Legislative Assembly of Ontario, 2019). While it was later deemed unconstitutional by the Ontario Superior Court, this contributed significantly to the discontent of nurses in Ontario (Callan & D'Mello, 2023; Whittington, 2024).

While nursing shortages and deteriorating working conditions predate the pandemic, a tsunami has taken place across the country with many nurses deciding that they have had enough, spurring them to retire early, leave the public system, or leave the profession. Figure 1 shows the rising vacancies for RNs, RPNs and LPNs between 2015 and 2023 (Statistics Canada, 2024a; 2024b). In 2015, there were 6,530 vacancies reported for RNs and RPNs. In 2019, before COVID-19 started, there were 10,575 vacancies for RNs and RPNs. This number rose 2-fold to 21,045 vacancies in 2020 and rose further to 28,740 at the end of 2023. This was a 4.4-fold increase over eight years. Data for LPNs show a similar trend with 1,585 vacancies in 2015. The vacancies rose by 91% from 3,710 vacancies in 2019 to 7,095 vacancies in 2020 and rose further to 13,285 vacancies at the end of 2023. This was an 8.4-fold increase over eight years. While not shown in Figure 1, the vacancies for NPs also rose from 95 in the fourth quarter of 2015 to 700 at the end of 2023, a 7.3-fold increase over eight years. The biggest jump in vacancies for NPs during the past five years was between 2021 and 2022 with a 63% increase from 515 to 840 vacancies (Statistics Canada, 2024b).

When we will start to see significant decreases in the number of vacancies is unknown as a 2022 Conference Board of Canada report revealed that Canada could lose approximately 20% of all health care workers to retirement between 2021 and 2026 (Francis et al., 2022). A poll conducted on behalf of two unions (Canadian Union of Public Employees and SEIU [Service Employees International Union] Health Care) reported that 60% of surveyed registered practical nurses in Ontario (LPNs) were considering leaving the profession (SEIU Health care, 2023). A CFNU (2024) survey conducted in early 2024 with 5,595 practicing nurses also reported that 40% of nurses (4 in 10) were still intending to leave the profession, leave their job or retire within the next year due to high workloads, insufficient staffing levels, lack of work-life balance, unpredictable staffing and scheduling, and inadequate compensation. While these surveys mainly used convenience sampling methods, and only measured the intention to leave the profession or change jobs (rather than actual turnover), the ongoing nursing shortage combined with the high use of agencies by health care facilities is ultimately unsustainable for the future of the Canadian health care system.

Purpose, research questions and methods

The overall purpose of this research study was to examine the high use of agencies across Canada. To do this, the following research questions were developed.

1. How many agencies have been used by Canadian health care facilities during each of the past four fiscal years?
2. How much has been spent by Canadian health care facilities on agency costs during each of the past four fiscal years?
3. How many agency hours have been used by Canadian health care facilities during each of the past four fiscal years?
4. In which sectors and/or settings have agencies been used in Canada during each of the past four fiscal years?
5. What were the hourly agency rates in Canada and which factors affected these rates during each of the past four fiscal years?
6. How many regulated nurses have worked with agencies in Canada during each of the past four fiscal years?
7. Why are regulated nurses in Canada choosing to work with agencies?
8. What are nurses' experiences working with agencies in Canada?
9. What are nursing students' perceptions of working with agencies in the future?
10. Why are health care facilities in Canada using agencies?
11. What are the experiences of managers and nurses working in health care facilities using agencies?
12. What are the advantages and disadvantages of Canadian health care facilities using agencies?
13. What are the implications of using agencies in Canada?
14. What impact has agency use had on the Canadian public health care system?
15. What strategies and initiatives are being used in Canadian health care facilities to retain nurses to ensure agencies are not needed?
16. What Canadian provincial/territorial initiatives have been implemented or brought forward?
17. What more must be done to reduce the use of agencies in Canada?
18. Where should the Canadian nursing profession go from here?

To answer the research questions, multiple methods of data collection were used and are summarized below.

01. Review of existing and emerging literature

A scoping review was conducted using the methodological framework developed by Arksey and O'Malley (2005) and Levac et al. (2010). A comprehensive search approach was employed in two steps to locate information in the form of peer-reviewed articles, media articles, dissertations, and government documents examining nursing agencies. The findings from the review are integrated throughout the report where applicable.

A. The first step focused on literature specific to Canada. A preliminary search was conducted in Google Scholar, followed by an analysis of relevant studies, to identify applicable text words and database-specific subject headings. A comprehensive search approach was developed in Ovid MedLine then adapted for Ovid Embase, EbscoHost CINAHL, Policy Commons and Factiva. The peer-reviewed literature databases were searched from inception to July 11, 2023. The grey literature and media sources (Policy Commons, Factiva and Google Scholar) were searched for the past five years to ensure the most recent information was included. Search terms included "agency nurs*", "agency staff*", "temporary nurs*", "temporary staff*", "casual pool", "staffing agency" in combination with Canada and each of the provinces and territories. A total of 148 information sources were found in the initial search. After four duplicates were removed, 144 sources were screened by one reviewer to determine preliminary eligibility based on the research questions identified above with 106 sources being excluded after abstract review. In total, zero peer-reviewed articles and 38 media articles met the inclusion criteria. An updated search was recently conducted from July 2023 to July 2024, identifying one published journal article meeting the inclusion criteria, for a total of 38 media articles and one peer-reviewed article being included. Using Google alerts and other information sources, media articles continued to be reviewed weekly until the end of July 2024. The final number of Canadian media articles reviewed and included was not calculated as this was dependent upon the primary data obtained from other sources.

B. The second step expanded the focus to include international literature using the same search strategy. While databases were searched from inception to October 30, 2023, the inclusion criteria were changed to include only literature from 2000 onwards. Grey (international) literature searching was not included due to the volume of literature. The number of results from all databases searched was 6,449, which was reduced to 4,670 after 1,779 duplicates were removed. After title and abstract review, an additional 3,929 records were excluded with 741 articles sought for full-text review by two reviewers. Following full-text review, 492 articles were excluded, and 249 articles or reports were reviewed further to determine their alignment with the research questions in this report. Reports, general commentaries and overviews of the topic were excluded (n=208) with the final review of the international literature including 41 articles. This was combined with the one peer-reviewed article from the review of Canadian literature for a total of 42 articles (Table 1). Most articles were from the United States (n=17) and Australia (n=9), followed by United Kingdom (n=5), South Africa (n=5) and one each from Italy, Finland, Sweden

and Canada. Two articles were reviews which included articles from multiple countries. The most common settings in the articles were acute care (n=28) and LTC homes (n=6), followed by one each from hospices and rural/remote communities. Six articles were in mixed settings (e.g., acute care and long-term care).

02. Request for data from nursing regulators and CIHI's Health Workforce Database

To practise as a regulated nurse in Canada, annual registration with the appropriate provincial or territorial regulatory authority is mandatory, requiring the completion of a registration form which is then entered into each regulatory authority's registration database. Eleven nursing regulators across Canada were contacted to enquire about the number of nurses working with agencies based on their registration databases. Five regulators responded reporting that they do not collect/collate this data and directed the research team to CIHI. The College of Nurses of Ontario (CNO) had a Nursing Data Dashboard (CNO, 2024; data.cno.org/) which was used to retrieve data regarding the numbers of nurses in Ontario by filtering the employment setting by nursing/staffing agency and grouping by nurse type (RN and LPN).

Through an agreement with CIHI, each regulatory authority submits a set of standardized data to CIHI, collected using the registration forms, which is then entered into CIHI's Health Workforce Database (HWDB) (CIHI, 2023b). Data were requested from CIHI's HWDB regarding the number of RNs and LPNs, by jurisdiction, who reported working with an agency as their primary place of employment between 2018 to 2022. Data for RPNs and NPs were not provided due to the small numbers reported in each province and territory. The data file was received January 26, 2024.

03. First survey: chief nurse executives

A survey was distributed using the Queen's University Qualtrics platform to 141 chief nurse Executives (CNE) in 58 regional health authorities in nine provinces and two territories, 82 hospitals in Ontario, and one federal organization. Questions were developed by the research team and included the use of agencies, number of agency hours and nurses, average agency rate, total dollars spent, direct and indirect costs, total number of hours worked, and where agencies were being most frequently used. Recruitment material and surveys were available in French and English. Where possible, two to three reminder emails were sent to non-respondents to encourage participation. Participants were also offered the option of completing fillable Word surveys. The length of time to complete the survey varied depending on the CNE's or delegate's ease of access to the requested information.

Of the 141 surveys distributed, one health authority declined to participate due to the confidentiality of the contracts signed with agencies. One health authority advised that they could not provide the requested information through a survey but would require a request for Access to Information and Privacy Online Requests under the *Freedom of Information and Protection*

of Privacy Act. Twenty-two surveys were opened and reviewed with no data submitted. Eighty-five surveys were not opened. In total, 16 CNEs or delegates completed the survey and an additional 15 CNEs or delegates reported that their health care facility did not use agencies. The 31 health facilities who responded included nine health authorities, 21 hospitals and one federal organization (Table 1).Data were analyzed using descriptive statistics (frequences, range, means, standard deviations).

04. Requests for access to information under the *Freedom of Information and Protection of Privacy Act*

Eighteen Access to Information and Privacy Online Requests under the *Freedom of Information and Protection of Privacy Act* (ATIP/FOI) were submitted to the health authorities who had not responded to the survey. ATIP/FOI requests were not submitted to the individual hospitals who had not responded to the survey due to the large number. Two health authorities advised us that they do not collect the information requested, seven health authorities did not respond, and requests to two health authorities were cancelled due to prohibitive costs associated with completing the request. In total, seven health authorities completed the request and provided data (Table 2).

05. Requests to provincial nursing unions

Requests were made by the CFNU to provincial nursing unions to enquire about available data they had collected either through ATIP/FOI requests or from individual health authorities/hospitals. Seven provincial nursing unions were able to provide additional data used in this report with permission (Table 2).

Table 1
Data collection methods and responses

	#
Scoping review (Canadian and international)	
Studies screened	4,814
Included in final review	42
Requests to regulators	
Contacted	11
Responses	5
Data available	1
CIHI HWDB	received
First survey: CNEs	
Total sent	141
Responded • No agency use • Completed survey	31 15 16
Opened survey only	22
Declined	1
Required ATIP/FOI	1
No response	85

Table 2
ATIP/FOI requests and requests to provincial nursing unions

ATIP/FOI	
Submitted	18
Provided data	7
Data not available	2
High cost	2
No response	7
Provincial nursing unions	
Sent	9
Data received	7

06. Second survey: nurses, managers and students

To obtain the perspectives of current and future nurses about agencies, an anonymous survey using the Queen's University Qualtrics platform was distributed to three groups which were created based on the following inclusion criteria: 1) nurses who currently work with or previously worked with a private nursing/staffing agency in Canada within the past 5 years; 2) nurses and managers who work in health care facilities in Canada which use private nursing/staffing agencies; and, 3) pre-graduate nursing students in the last year of their program at a Canadian institution. The study's definition of agencies was provided in each group's letter of information and again at the start of the survey. Survey questions for each group were developed by the research team to examine various aspects of working with agencies, working in public institutions who use agencies, and the perspectives of future nurses. The surveys took approximately 10 minutes to complete. Participants had the option of entering a draw for a chance to win one of 10 gift cards of their choice through the Everything Card platform, each valued at $50.

Recruitment of participants required various strategies to reach as many participants as possible over a three-month span. All recruitment material and surveys were available in French and English.

1. To recruit students, the Canadian Nursing Students' Association shared recruitment material on their social media platforms.

2. To recruit nurses and managers, requests were submitted to nursing regulators in selected provinces based on the regulator's timeline for processing the request and if recruitment material could be distributed by email or social media. Three regulators did not respond to our requests, one indicated that they could not email members solely for research purposes, and two could not meet our timeline. Six regulators were able to facilitate the distribution of recruitment material based on the following internal processes: 1) emails were distributed by the regulator to a select number of members (e.g., 3,000) who provided consent to be contacted for research purposes (British Columbia); 2) emails were distributed to all members who provided consent to be contacted for research purposes (Manitoba, New Brunswick, Newfoundland and Labrador); 3) recruitment materials were posted on the regulator's social media (Saskatchewan); and 4) email addresses of members who agreed to be contacted for research purposes (Alberta) were provided to the research team with the research team distributing emails to a portion of this population (e.g., 3,000). No regulator was able to determine which members worked or did not work with agencies.

Recruitment materials were also distributed by the CFNU to provincial nursing unions, who distributed to their members or posted on their social media. It is unknown how many of the provincial unions distributed the recruitment material. It is also unknown how many potential participants were recruited to participate; therefore, the response rate cannot be calculated. Data were analyzed using descriptive statistics (frequences, range, means, standard deviations).

Survey responses by group

Nurses working with agencies (past and present) in Canada

1051 surveys were opened with 314 surveys started but not submitted (no data accessible). On the screening questions, 13 participants indicated they were not eligible as they did not work with an agency in Canada. After reviewing the submitted surveys, an additional 132 surveys were removed (two had no or minimal data provided, 130 did not meet the inclusion criteria). The final sample was 592 participants.

Just over 85% identified as women, with an average age of 39 years (SD=11.1; range 22 to 72), 13 years working as a nurse (SD=12.7; range 0.6 to 50.8), and eight years working in their current specialty (SD=7.8; range 0.3 to 42). The largest number of participants were between 30 and 39 years, followed by 20 and 29 years, and 40 and 49 years (Table 3). Sixty-six percent reported that they currently worked with an agency, while close to 34% previously worked with an agency during the past 5 years with the majority stopping in 2022 and 2023.

Participants reported being located in 12 provinces and territories (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Nunavut and Northwest Territories) with the majority in Ontario, Manitoba, British Columbia and Alberta. Participants were from each nursing designation with close to 88% being an RN, followed by LPN, NP and RPN (Table 3). Bachelor's degree (73.4%), college diploma (18.1%) and master's degree or above (8.3%) were reported as the highest level of nursing education.

Table 3
Nurses working with agencies (past and present): selected demographics

Variable	%
Gender	
Woman	85.3
Man	13.4
Transgender	0.5
Non-binary	0.2
Prefer not to say	0.7
Age category	
20-29	22.9
30-39	37.5
40-49	20.2
50-65	17.3
65+	2
Location	
British Columbia	19.1
Alberta	12.3
Saskatchewan	0.5
Manitoba	22.7
Ontario	32.8
Quebec	1.2
New Brunswick	3.1
Nova Scotia	3.1
Prince Edward Island	0.2
Newfoundland and Labrador	2.9
Nunavut	0.5
Northwest Territories	0.2
Yukon	-
Multiple locations	1.4
Nursing designation	
Registered nurse	87.6
Licensed practical nurse	10
Nurse practitioner	2.2
Registered psychiatric nurse	0.2

Nurses and managers who work in health care facilities in Canada which use agencies

1564 surveys were opened with 308 surveys started but not submitted (no data accessible). On the screening questions, 195 participants were not eligible as nine did not work in Canada, 77 did not work in a public health care facility, 17 worked with an agency and were redirected to the other survey, and 92 did not work in a health care facility which used agencies.

After reviewing the submitted data, an additional 11 surveys were removed (two had no data provided, 9 did not meet the inclusion criteria). The final sample was 1,050 participants (95 managers, 955 nurses).

Managers

Just over 90% identified as women, with an average age of 50 (SD=10.1; range 29 to 70), 5 years working as a manager (SD=5.3; range 0.1 to 27) and 24 years working as a nurse (SD=11.1; range 3.5 to 50). The largest number of participants were between 50 and 64 years and 40 and 49 years (Table 4). Participants reported being located in seven provinces and territories (British Columbia, Alberta, Manitoba, Ontario, New Brunswick, Newfoundland and Labrador, and Nunavut) with the majority in Alberta, Manitoba and British Columbia. Participants were from each nursing designation with 91.6% being an RN (Table 4). Bachelor's degree (52.6%), college diploma (22.1%) and master's degree or above (25.3%) were reported as the highest level of nursing education.

Nurses

Just over 91% identified as women with an average age of 42 (SD=11.5; range 22 to 80), 17 years working as a nurse (SD=11.7; range 0.3 to 60) and 11 years working in their specialty areas (SD=9.0; range 0.1 to 47). The largest number of participants were between 30 and 39 years and 50 to 64 years (Table 4). Participants reported being located in 10 provinces and territories (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, and Yukon) with the majority in Ontario, British Columbia, Alberta and Manitoba. Participants were from each nursing designation with 90.9% being an RN (Table 4). Bachelor's degree (69.2%), college diploma (22.6%), master's degree or above (8.1%) and CEGEP (0.1%) were reported as the highest level of nursing education.

Pre-graduate nursing students

32 surveys were opened with six surveys started but not submitted (no data accessible), and three participants were not eligible as they indicated they were not current pre-graduate nursing students. The final sample was 23 participants. All were women with an average

Table 4
Managers and nurses working in health care facilities which use agencies: selected demographics

Variable	Managers	Nurses
	%	%
Gender		
Woman	90.5	91.5
Man	9.5	7.4
Transgender	-	0.2
Non-binary	-	0.1
Prefer not to say	-	0.7
Age category		
20-29	1.1	13.3
30-39	16.3	34.6
40-49	28.3	23.1
50-64	43.5	26.3
65+	10.9	2.8
Location		
British Columbia	18.5	20.4
Alberta	27.2	15.6
Saskatchewan	-	0.4
Manitoba	20.7	10.8
Ontario	14.7	37.2
Quebec	-	-
New Brunswick	7.6	2.5
Nova Scotia	-	3.1
Prince Edward Island	-	1.1
Newfoundland and Labrador	9.8	8.5
Nunavut	1.1	-
Northwest Territories	-	-
Yukon	-	0.1
Nursing designation		
Registered nurse	91.6	90.9
Licensed practical nurse	4.2	6.4
Nurse practitioner	1.1	1.4
Registered psychiatric nurse	3.2	1.4

age of 27 (range 21 to 49). The largest number of participants were between 20 and 29 years (75%), followed by 30 and 39 years (20%) and 40 and 49 years (5%). Participants were located in six provinces and territories (Ontario, British Columbia, Alberta, Manitoba, New Brunswick, Prince Edward Island, Northwest Territories) with the majority in Ontario (33.3%) and British Columbia (28.6%). Participants were currently enrolled in education programs for RNs (72.8%), LPNs (13.6%) and NPs (13.6%). The majority of participants were interested in practicing in an emergency department (ED), critical care unit and primary care setting, followed by the operating room/post-anesthetic care unit and various inpatient units.

07. Semi-structured interviews

To obtain a more in-depth perspective from nurses who currently work with or previously worked with an agency in Canada within the past 5 years, employers who use or do not use agencies, and Canadian nurse leaders, semi-structured interviews were conducted with 18 nurses from across Canada between March 22 and May 3, 2024 (Table 5). Interviews were approximately 60 minutes in duration, and informants were offered a $30 honorarium for their participation. Participants were asked about their experiences and perspectives on the use of agencies in Canada. All interviews were conducted by Graduate Research Fellows and were fully transcribed by a professional transcription company. Data were analyzed using qualitative content analysis.

Similar to the surveys, a mix of recruitment strategies were used.

1. Nurses who currently work with or previously worked with an agency in Canada within the past 5 years were invited to participate in an interview at the end of the online survey. If they were interested, they were asked to provide their preferred email address, gender, province where they worked and age category. This resulted in 289 nurses responding with interest. With a goal of obtaining a diverse sample from across the country, potential participants were selected based first on the province where they worked, then age category, then gender. They were contacted via email with an invitation to participate and a letter of information describing the study and ethical considerations. If a response was not received, one reminder email was sent. If they were still interested, they were asked to contact us. Eighteen invitations were sent, with 6 nurses agreeing to participate. One nurse declined, one nurse cancelled the interview and did not reschedule, and 10 nurses did not respond to the invitation.

   The six interview participants reported working in six provinces including British Columbia, Alberta, Saskatchewan, Nova Scotia, Newfoundland and Labrador and Yukon. Most participants were between 21 and 30 years of age, followed by 31 and 40 years of age, and 61 and above with an equal number identifying as men and women. During the interviews, participants further reported that they were LPNs working in ED or medicine and RNs working in medicine,

Table 5
Semi-structured interview responses

Nurses working with agencies	
Invited	18
Accepted	6
Declined/cancelled	2
No response	10
Employers who use or do not use agencies	
Invited	10
Accepted	6
No response	4
Canadian nurse leaders	
Invited	11
Accepted	6
Declined	2
No response	3

ED or critical care. 50% had worked in rural and northern communities. Their range of time working for agencies was 6.5 years to recently completing their first contract. Most worked with only one agency. A small number stopped working with agencies during the past three years.

2. Employers who use or do not use agencies were invited to participate in the interviews in the two ways:

   1. The list of 31 CNEs who responded to the first survey were categorized by their facilities' location in Canada, if urban or rural/remote, if currently used or did not use agencies and facility size. With a goal of obtaining a diverse sample from across the country, potential participants were then selected based on these categories. From this list, six CNEs were invited to participate, with four accepting, and no response from the remaining two.

   2. Managers who completed the second survey were also invited to participate in an interview, similar to the process outlined above for nurses working with agencies. Thirty-eight participants expressed interest and were categorized by province, age category, and gender. From this list, four managers were invited to participate with two accepting and no response from the remaining two.

   The six interview participants reported working in Ontario, British Columbia and New Brunswick. Two worked at health care facilities who never used agencies, both in urban settings. Of the four participants who worked in health care facilities that did use agencies, two worked in small, rural/remote settings (including a LTC home), and two worked in larger urban settings.

3. Canadian nurse leaders were invited to participate in the study based on their professional role. They were all recruited via an email invitation with a letter of information about the study and ethical considerations. With a goal of obtaining a diverse sample from across the country, potential participants were selected based on their role and their location. Eleven leaders were invited to participate, with six accepting, two declining and no response from the remaining three. The six participants were located in five different provinces and to ensure anonymity, additional demographics are not provided.

This study received ethical approval by the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board where applicable.

Results

Data were analyzed to answer each research question presented earlier. A summary of the data resources used and available data for each province and territory are provided in Appendix A.

01. How many agencies have been used by Canadian health care facilities during each of the past four fiscal years?

A list of agency names was developed based on ATIP/FOI requests, Chief Nurse Executives (CNE) surveys, provincial nursing unions, surveys from nurses working with agencies, and media articles. Appendix B lists the name of 472 agencies that were identified from these data sources and the provinces or territories where they were reported to provide services. Several agencies provided services within one province only while many others provided services across two or more provinces, and at least 11 agencies provide services through federal contracts. The agencies most frequently identified in the surveys from nurses working with agencies were Solutions Staffing (n=104), Select Medical Connections (n=79), and Elite Intellicare Staffing (n=44).

Agency websites were reviewed to obtain more details; however, the information was not always clear, and some websites provided little detail. There was also complexity determining which agencies were independently owned, in which province or territory they provided services, and which agencies were part of larger corporations. The list in Appendix B is not all-inclusive and does not differentiate between types of agencies (e.g., home care and community care versus multiple settings) or between for-profit and not-for-profit agencies. It is also noted that some agencies listed in Appendix B may provide services other than nursing.

Number of agencies per health authority or health care facility

In data collected from 129 hospitals by the Ontario Nurses' Association (ONA) (2023) from 2021 to 2023, the number of hospitals using agencies increased each year. In 2021, 32 hospitals reported spending on agencies. This increased to 54 hospitals in 2022 then to 75 hospitals during the first two quarters of 2023. Region 5 (Ontario Health West – Southwestern Ontario) had the lowest number of hospitals who reported spending on agencies in 2022-2023 (n=4, 19% of 18 hospitals in the region who provided data). In response to our survey sent to CNEs, 15 participants reported that they do not use agencies. Fourteen were in hospitals in Ontario, and one was a health authority.

Based on other data obtained for this report, Table 6 breaks down the number of agencies by health authority or hospital by jurisdiction. Over the past four years, the number of agencies used by the majority of health authorities and hospitals has fluctuated between 2020-2021 and 2022-2023. During this time frame (not including 2023-2024), seven increased the number of agencies each year and one decreased each year, while the remainder either remained the same or had fluctuating increases and decreases. Three of the health authorities in Quebec reported using the highest number of agencies with one reporting a range of 249 to 262, but it is unknown if all of these were specifically nursing agencies.

Table 6
Number of agencies per health authority or health care facility by jurisdiction during past 4 years using available data

	2020–2021	2021–2022	2022–2023	2023–2024 (3 quarters)
British Columbia Fraser Health Authority (2024)	n/a	n/a	n/a	17
British Columbia Vancouver Coastal Health (2024a)	2	7	14	16
Alberta Health Services (Alberta Health Services, 2022; French, 2023; United Nurses of Alberta, 2021)	5	10	n/a	n/a
Alberta Covenant Health (French, 2023)	n/a	5	7	n/a
Saskatchewan Health Authority (Saskatchewan Union of Nurses, 2023; 2024)	n/a	n/a	n/a	15
Manitoba Prairie Mountain Health (2024)	8	26	30	30
Manitoba Southern Health-Santé Sud (2024)	10	33	38	31
Manitoba Northern Health Region (2024)	15	25	45	35
Manitoba Interlake-Eastern (2024)	n/a	n/a	n/a	58
Ontario hospitals (7 CNE surveys)	1	1 to 5	1 to 6	2 to 7
Quebec health authority 1 (CNE survey)	2	4	6	7
Quebec health authority 2 (CNE survey)	33	31	35	54
Quebec health authority 3 (CNE survey)	93	93	92	77
Quebec health authority 4 (CNE survey)	46	64	47	36
Quebec health authority 5 (CNE survey)	286	283	249	262
New Brunswick two health authorities (Ha et al., 2024; CNE survey)	0	2	10	11
Nova Scotia Health (McPhee, 2023)	n/a	n/a	8	n/a
Health PEI (2024)	n/a	n/a	n/a	6
Newfoundland and Labrador four health authorities (Ha et al., 2024)	n/a	n/a	n/a	4
Northwest Territories Health and Social Services Authority (Carroll, 2024)	n/a	n/a	n/a	6
Yukon Health and Social Services (CNE survey)	3	3	3	5
Federal organization (CNE survey)	6	4	5	5

n/a – not available

02. How much has been spent by Canadian health care facilities on agency costs during each of the past four fiscal years?

To determine the costs associated with agencies in Canada, data were obtained through ATIP/FOI requests, surveys sent to CNEs provincial nursing unions, media articles and CanadaBuys website (Government of Canada, 2024a). Appendix C provides a detailed overview of the total costs by health authority/health care facility by jurisdiction. While the focus was of the study was on the past four fiscal years, data obtained prior to this were also included if available. Note the costs are much higher than reported in the appendix due to differences in reporting as well as the lack of available data for several jurisdictions. Caution should also be used in comparing the data across jurisdictions as the details about information included in the costs was not always reported. For example:

- LTC costs may or may not be included.
- Reported costs may represent costs associated with compensation for hours worked, without including how much was paid for travel and/or accommodation costs.
- Separating costs for different categories of agency staff was not always feasible, therefore some reported costs may include only regulated nurses while others may include other agency staff such as unregulated workers.
- Health authorities with rural facilities often reported higher costs due to the travel costs paid to nurses for travelling to, from and between facilities or a client's home.

Using the data outlined in Appendix D and Table 7, the total costs associated with the use of agencies are presented in Figure 2 for the past 4 fiscal years where data was available. As illustrated, the costs rose from $247.9M in 2020-2021 to $717.2M in 2021-2022 to $1.2B in 2022-2023 to a projected $1.5B for 2023-2024, a 6-fold increase in just three years. Most of the 2023-2024 data obtained for this report only reflected part of that fiscal year, therefore cost projections were calculated for the full fiscal year where possible. For example, if costs were provided for the first three quarters, this cost was divided by nine months then multiplied by 12 months to project the costs for the full year. All available data were used to calculate the costs; however, data sources were selected to avoid overlap between data, and only the last 4 years were selected to capture the most available data across jurisdictions. Many provinces did not have data available for all health authorities or health care facilities each fiscal year. For example, data for 2023-2024 fiscal year in British Columbia only included three health authorities compared to five health authorities in previous three years.

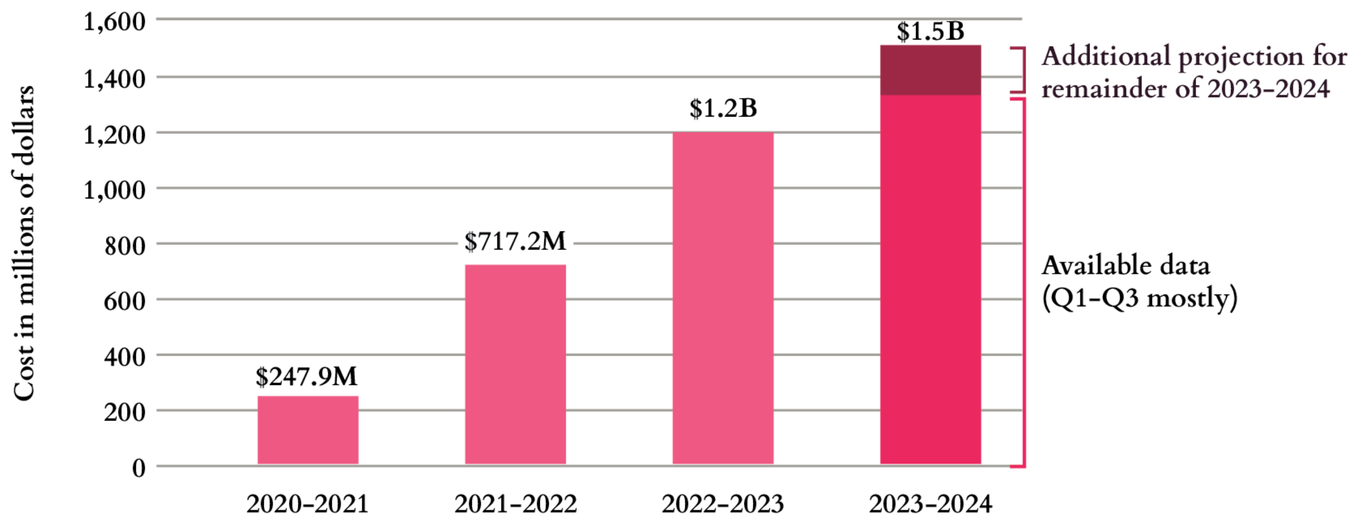
Table 7
Overview of available jurisdictional data used in Figure 2 to calculate total costs spent on agencies

Jurisdiction	2020–2021	2021–2022	2022–2023	2023–2024 (available data Q1–Q3 mostly)	Additional projection for remainder of 2023–2024
British Columbia	$28,900,000	$73,700,000	$162,700,000	$35,100,000	$7,600,000
Alberta	$5,000,000	$5,400,000	$2,200,000	n/a	n/a
Saskatchewan	$1,400,000	$12,300,000	$45,300,000	$59,200,000	2023–2024 data is for full calendar year
Manitoba	$33,500,000	$55,800,000	$59,700,000	$43,300,000	$17,000,000
Ontario	$38,100,000	$368,600,000	$600,200,000	$600,200,000*	n/a
Quebec	$77,500,000	$107,000,000	$131,800,000	$207,500,000	$69,300,000
New Brunswick	n/a	n/a	$10,900,000	$109,600,000	$62,600,000
Nova Scotia	$3,100,000	$18,400,000	$61,500,000	$126,000,000	n/a
Prince Edward Island	$27,942	$700,000	$1,400,000	$8,800,000	2023–2024 data is for full fiscal year
Newfoundland and Labrador	n/a	n/a	$100,000,000	$86,700,000	$17,300,000
Northwest Territories	n/a	$531,568	$5,300,000	$4,400,000	n/a
Yukon	$1,500,000	$1,000,000	$1,400,000	$1,300,000	$300,000
Federal organization	$58,900,000	$73,800,000	$51,500,000	$21,700,000	$4,300,000
Total	**$247,927,942**	**$717,231,568**	**$1,236,800,000**	**$1,298,100,000**	**$178,400,000**

*Comparable data not available for Ontario in 2023–2024, therefore cost data from 2022–2023 used.
*n/a – not available

Figure 2

Total costs spent on agencies by health care facilities in Canada over past four fiscal years using available data



Note: Costs are much higher than reported due to differences in reporting and lack of available data for some jurisdictions. Data sources used in this figure are provided in Appendix D **and** Table 7**.**

The provinces and territories reporting the most data each year included Saskatchewan, Manitoba, Prince Edward Island and Yukon. A federal organization also provided data for each year. The data for the remaining provinces and territories were based on data collected from some health authorities in the province (Quebec), some health authorities or hospitals in the province and media articles (British Columbia, Ontario, New Brunswick, Nova Scotia), or only using media articles or auditor general reports (Alberta, Newfoundland and Labrador, Northwest Territories). As comparable data were not available in Ontario for the 2023-2024 fiscal year, the cost data from 2022-2023 were used.

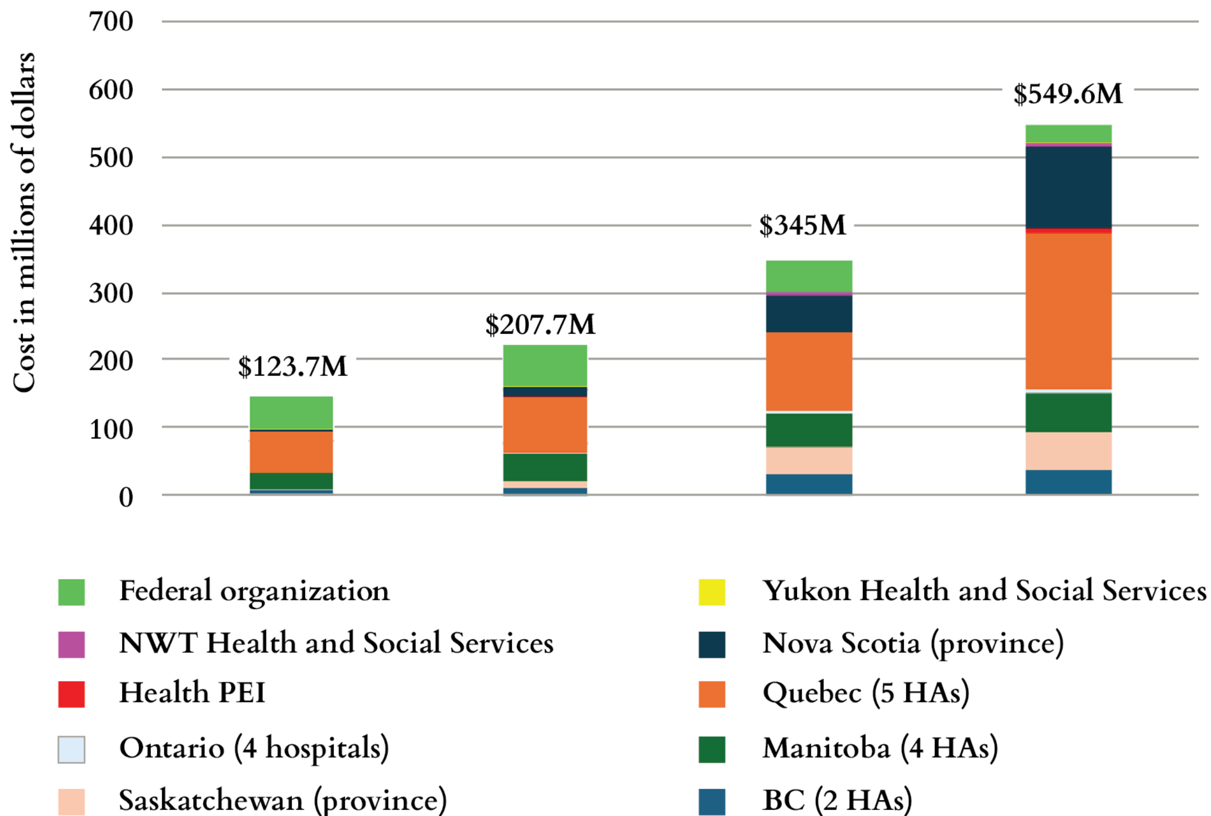
Data were reported by some facilities prior to 2020, which illustrated that health authorities and hospitals have used agencies for many years. The data obtained and presented demonstrates the significant rise in the costs associated with agencies across jurisdictions in the past four years. For example, five health authorities in British Columbia reported spending $12.8M in 2018-2019, then spent almost 13 times this amount at $162.7M in 2022-2023. During the same period, Alberta's costs rose from $450,000 to 11.3 times this amount at $5.1M. Data collected by ONA (2023) from 129 hospitals also found that the number of hospitals using agencies, and their costs had risen dramatically since 2021. In 2021, 32 hospitals spent between $833 to $6,713,981 while in 2022, 54 hospitals spent $602 to $7,986,520. Then during the first two quarters of 2023, 75 hospitals spent $7,723 to $18,097,650. Eighteen hospitals reported no spending on agencies in 2022, then reported significant agency spending in 2023. However, the data also showed that 15 hospitals were able to decrease their spending on agencies between 2022 and 2023.

Comparison of expenditures on agencies with permanent nursing staff positions

In the Legislative Assembly, the Government of Northwest Territories was asked to provide the total number of permanent nursing staff positions in the public service that could be funded from an equivalent expenditure on agencies. They reported that total expenditures by the Health and Social Services system on agency nurses for 2023–2024 was $4.4M, and the average cost of a permanent registered nurse position in 2023–2024 was $143,000. Therefore, the 2023–2024 expenditure on agency nurses was equivalent to 31 registered nurse positions (Northwest Territories Legislative Assembly, 2024).

Figure 3

Total available costs spent on agencies across a subset of 21 health care facilities with data consistently reported each year



Subset of costs

Using a subset of cost data (Appendix E and Table 8) that were consistently reported across a set of 21 health authorities and hospitals in nine provinces/territories and one federal organization, Figure 3 further illustrates how the total costs have increased in each of the past four years across this same set of health care facilities. Apart from a small number of facilities, this trend was evident in the rising costs reported by facilities in this study. Most facilities reported a significant increase in agency costs between the 2020-2021 and 2021-2022 fiscal years, while a smaller number reported a significant increase a year later between the 2021-2022 and 2022-2023 fiscal years. Projections for 2023-2024 fiscal year were calculated using the same criteria previously outlined for Figure 2. As illustrated in Figure 3, the costs rose from $123M in 2020-2021 to $207.7M in 2021-2022 to $345M in 2022-2023 to a projected $549.5M for 2023-2024, a 4.5-fold increase over three years. Similar to the total costs reported previously, the data obtained and presented demonstrates the consistent yearly rise in the costs associated with agencies across this subset of health care facilities.

Table 8
Overview of available jurisdictional data used in Figure 3 to calculate total costs spent on agencies by a subset of 21 health care facilities

Jurisdiction	2020-2021	2021-2022	2022-2023	2023-2024 projected total cost
British Columbia (2 health authorities)	$9,300,000	$17,900,000	$38,800,000	$40,800,000
Saskatchewan (province)	$1,400,000	$12,300,000	$45,300,000	$59,200,000
Manitoba (4 health authorities)	$30,900,000	$51,700,000	$55,600,000	$60,300,000
Ontario (4 hospitals)	$0	$1,300,000	$3,857,900	$6,800,000
Quebec (5 health authorities)	$77,500,000	$103,900,000	$131,800,000	$241,700,000
Health PEI	$27,942	$700,000	$1,400,000	$8,800,000
Nova Scotia (province)	$3,100,000	$18,400,000	$61,500,000	$126,000,000
NWT Health and Social Service	$0	$531,568	$5,300,000M	$4,400,000
Yukon Health and Social Services	$1,500,000	$1,000,000	$1,400,000	$1,600,000
Federal organization	$58,900,000	$73,800,000	$51,500,000	$26,000,000
Total	**$123,727,942**	**$207,731,568**	**$344,957,900**	**$549,600,000**

Additional federal contracts

While one federal organization did participate in the survey for CNEs, additional data from the CanadaBuys website (Government of Canada, 2024a) were also obtained for federal contracts since 2019. Using the search term 'nursing', 130 contracts with 12 agencies totalling more than $3.2B were located for the Department of Indigenous Services Canada (ISC), Health Canada, Public Health Agency of Canada, Royal Canadian Mounted Police and Veterans Affairs Canada. The contracts with ISC outlined that the contracts were to provide temporary nursing services needed to supplement workforce in delivery primary and public health, however other contracts only indicated nursing care services or health care services. If the total costs reported previously in Table 7 by one federal organization who participated in this study are removed from the $3.2 B, this still includes a total cost of $3B spent on federal contracts with agencies who provide nursing care or health care services. This amount is not included in Figure 2. Appendix F provides more details about the federal contracts.

03. How many agency hours have been used by Canadian health care facilities during each of the past four fiscal years?

In the survey with nurses and managers who work in health care facilities which use agencies, 65% of managers and 74% of nurses reported that the use of agencies had increased over the past five years (Table 9).

Table 9
Change in agency use over past 5 years: surveys completed by managers and nurses working in health care facilities which use agencies

	Managers	Nurses
	%	%
Increased	64.9	74.3
Decreased	21.3	15.6
Stayed the same	13.8	10.1

To determine the actual number of agency hours used by health authorities and health care facilities in Canada, data were obtained through ATIP/FOI requests, surveys sent to CNEs, provincial nursing unions, CIHI (2023) and media articles. Data were not available for six provinces or territories. Appendix G provides a detailed summary of the hours across jurisdictions where possible for the past four fiscal years or longer. The most hours were reported for RNs and LPNs. No hours were reported for RPNs, and only one federal health care facility reported hours for NPs with 5,327 hours in 2020-2021 and 11,310 hours in 2021-2022.

Similar to total costs, actual hours used will be much higher than those described in this report due to differences in reporting and lack of reporting from some jurisdictions. Caution should also be used in comparing the data across jurisdictions as all that may be included in the hours is not always reported. For example:

- LTC hours may or may not be included.
- The reported hours may be combined or may be separated into hours worked as well as hours associated with travel time.
- Separating hours for different categories of nurses was not feasible for all health care facilities, therefore some reported hours include both RNs and LPNs together or separated. Some reported data may also include other agency staff such as unregulated workers.

Data were provided by some health authorities and health care facilities prior to 2020. The numbers reflect how agency hours have dramatically increased during the past seven years. For example, Winnipeg Regional Health Authority reported using 1,226 hours in 2016-2017, with a 52-fold increase to 63,835 hours in 2022-2023 (Manitoba Nurses Union, 2024). Prairie Mountain Health reported using 78,216 hours in 2016-2017, with a 4-fold increase to 296,104 hours in 2022-2023 (Manitoba Nurses Union, 2024). Hospitals in northern Ontario reported purchasing just over 15,000 agency hours in 2018-2019, with a 26-fold increase to 391,000 in 2022-2023. And in British Columbia, data collected by the Health Employers Association of British Columbia (2024) and provided by the British Columbia Nurses' Union shows an increase from just under 23,000 agency nurse hours in Q1 of 2016-2017 to over 550,000 hours in Q3 of 2023-2024, a 24-fold increase (Figure 4). Other nursing unions which collected and provided data regarding agency hours included the Saskatchewan Union of Nurses, Manitoba Nurses Union and Ontario Nurses' Association.

Figure 4
Total agency hours reported in British Columbia since 2016

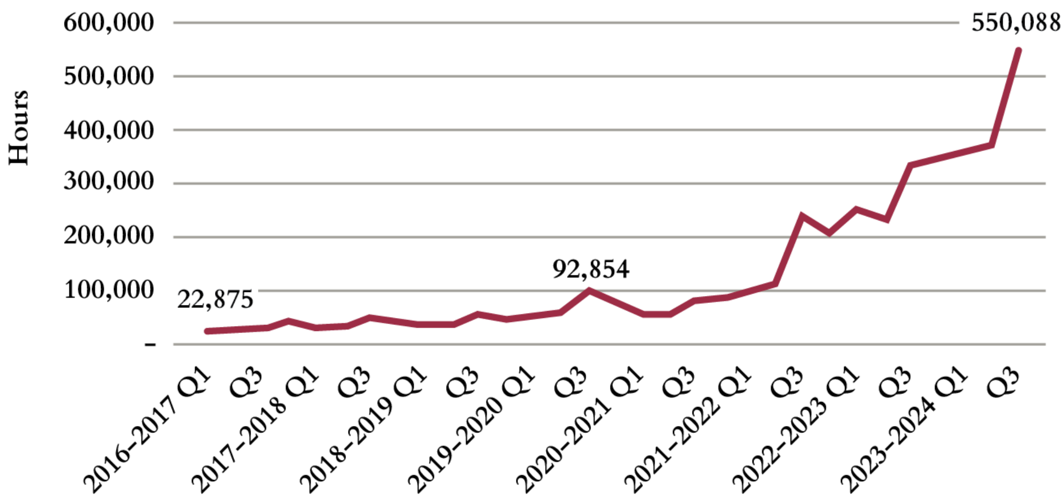


Figure created by the British Columbia Nurses' Union using data provided by the Health Employers Association of British Columbia (2024).

Figure 5
Total agency hours, RN agency hours and LPN agency hours used by health authorities and health care facilities using available data

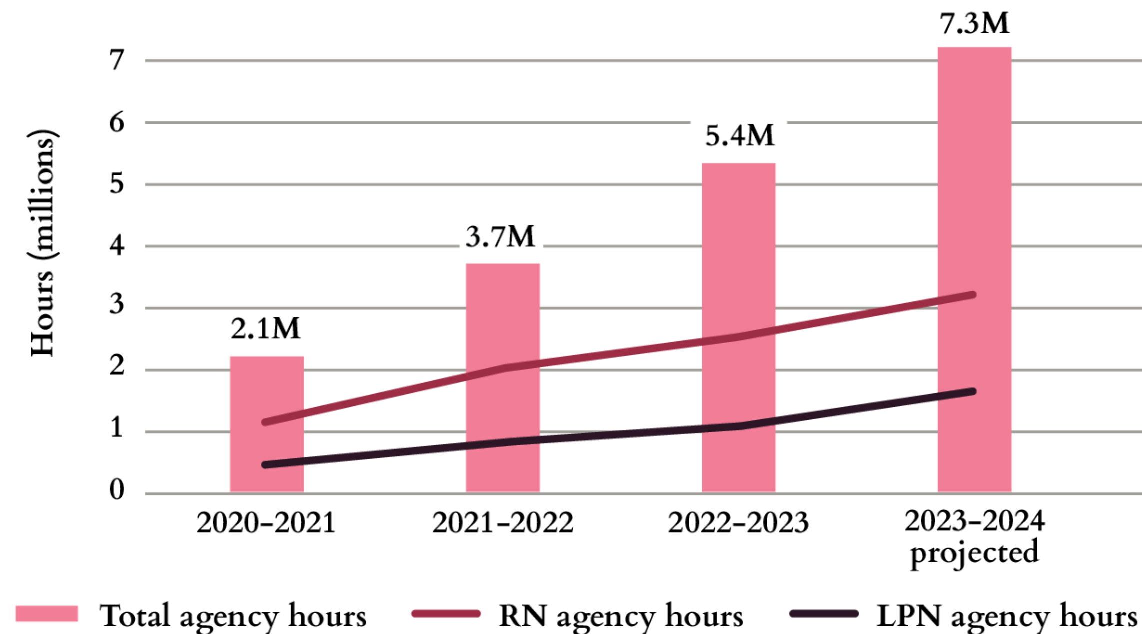


Table 10
Overview of available agency hours used in Figure 5

	2020-2021	2021-2022	2022-2023	2023-2024 projected
RN agency hours	1,118,024	2,007,762	2,495,312	3,215,886
LPN agency hours	399,992	775,139	1,070,695	1,560,294
Total agency hours	2,135,362	3,736,136	5,410,241	7,262,563

Using the data provided in Appendix H and Table 10, the total agency hours, number of RN hours and number of LPN hours used by health authorities and health care facilities during the past 4 years are presented in Figure 5. Some facilities reported only a total number of hours without a breakdown between RN and LPN hours and these numbers were included only in the total hours. Other facilities provided total hours as well as hours for RNs, LPNs, and NPs (where applicable). Therefore, the RN and LPN numbers are not completely reflected in the total hours, nor when added together do they always equal the total hours. As mentioned above, data were not obtained for six provinces or territories (Alberta, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Northwest Territories and Yukon). Except for Ontario and New Brunswick, the data were mostly complete for each fiscal year. In New Brunswick, data were only obtained for 2022-2023 and 2023-2024. In Ontario, comparable data were not available in Ontario for the 2023-2024 fiscal year, therefore the data from 2022-2023 were used.

As shown in Table 10, using available data between 2020-2021 and 2023-2024, there was a 3.4-fold increase in the total number of agency hours used, with a 75% increase between 2020-2021 and 2021-2022, a 45% increase between 2021-2022 and 2022-2023 and a 34% increase between 2022-2023 and 2023-2024. Between 2020-2021 and 2021-2022, three times more hours for RNs were required compared to LPNs, however this gap has closed. While the need for both groups has risen each year, LPN hours have increased almost 4-fold compared to the increase of 2.9-fold for RN hours across three years. Agency hours for RNs increased by 80% from 1.1M to 2M hours between 2020-2021 and 2021-2022, by 24% to 2.5M hours in 2022-2023 and by an additional 29% to 3.2M hours in 2023-2024 (projected). In contrast, LPN hours increased by 94% from 399,992 to 775,139 hours between 2020-2021 and 2021-2022, by 38% to 1.1M in 2022-2023 and by an additional 45% in 2023-2024 to 1.6M hours (projected). In a survey conducted by AdvantAge Ontario (2023) with 28 charitable and non-profit nursing homes and 14 municipal LTC homes, participants reported a 586% increase in agency hours for RNs and 587% increase in agency hours for LPNs between 2020 and 2023.

Figure 6
Comparison of total hours and full-time equivalents using available data

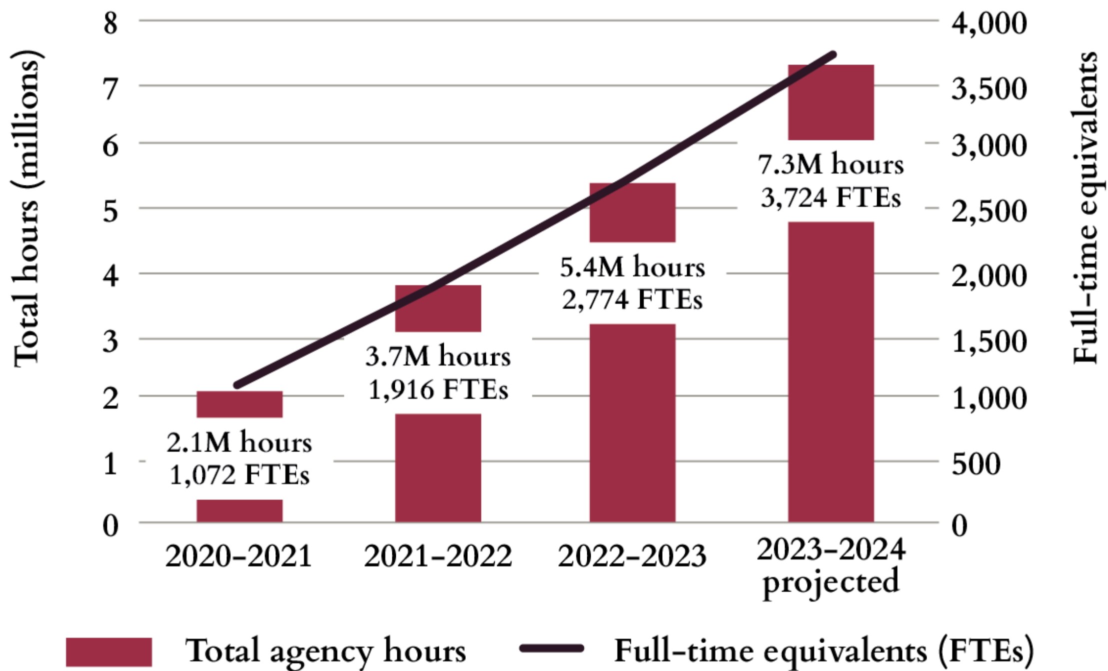
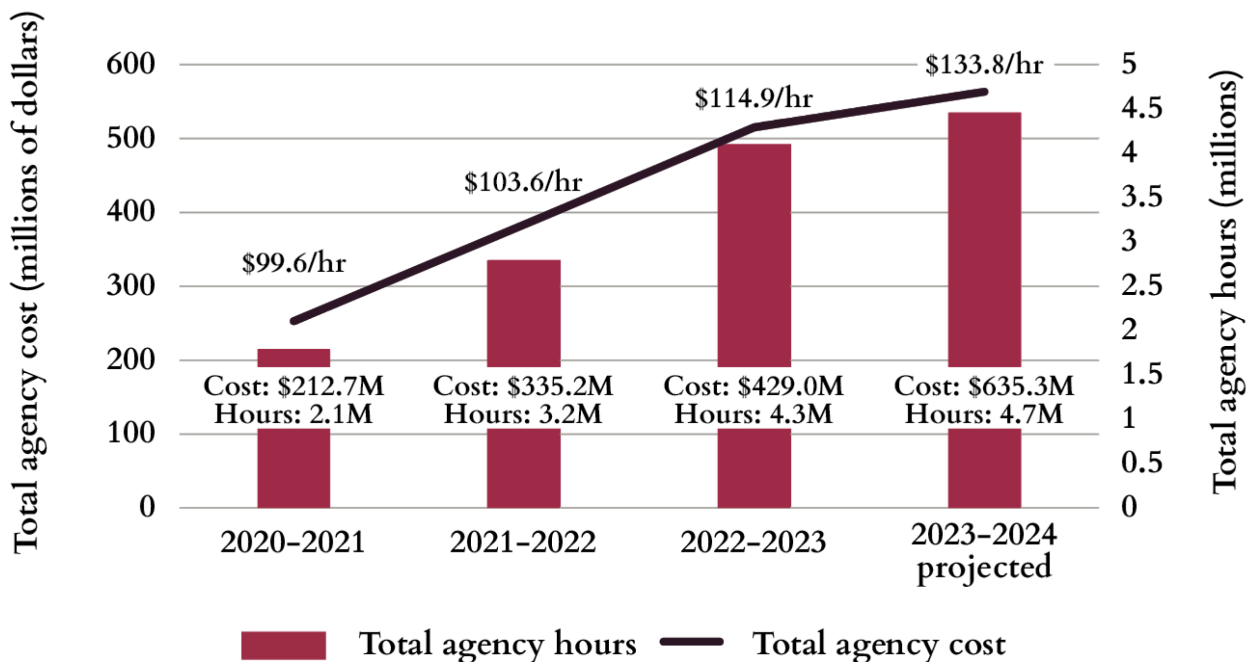


Figure 7
Comparison of total agency costs and total agency hours worked with average agency costs per hour calculated using available data



Full-time equivalents (FTEs)

To determine the number of FTEs for the total agency hours available, the number of total hours for each year was divided by 1,950 which is the assumed number of normal earned hours (i.e. worked hours) for 1 FTE in a given year. Figure 6 illustrates that 2.1M total hours in 2020–2021 are equivalent to 1,072 FTEs, while 7.3M total hours in 2023–2024 are equivalent to 3,724 FTEs. As noted previously this is an underestimate of actual agency hours and subsequent FTEs.

Rising agency costs per hour worked

Next, the total agency costs and the total agency hours worked were examined more closely using the available data from a subset of data from 18 health authorities and hospitals who reported data for both agency costs and total hours worked for at least two fiscal years over the past four years. The average agency costs per hour worked for each fiscal year were calculated by dividing the reported agency costs by the reported total hours worked each year. As shown in Figure 7, the average costs paid to agencies per hour for the selected 18 health authorities and hospitals in 2020–2021 were $99.6/hr. Between 2020–2021 and 2023–2024, this rate increased by 34% to $133.8/hr with a 17% increase between 2022–2023 and 2023–2024 and an 11% increase between 2021–2022 and 2022–2023. This increase may explain why some media articles question why costs are not aligning with the total hours being reported in some provinces. For example, in Newfoundland, the costs for agencies accounted for 14.5% of the province's spending on nurses between April and August 2023, despite agency hours accounting for only 5.4% of total nursing hours (Grant, 2024). An overview of the available data sources used in Figure 7 is provided in Appendix I.

Other agency hours reported

In 2023, CIHI reported on the number of hours purchased by hospitals and worked by nurses and other health care providers from agencies in Canada. While the hours only made up about 1% of the total volume of hours worked in hospital inpatient units, there was an 80% increase in the volume of purchased hours from 850,000 in 2020–2021 to over 1.5 million in 2021–2022 (CIHI, 2023a). However, those numbers were an underestimate as data from Northwest Territories, Alberta and Prince Edward Island were not included. Even with the rising use of agencies, nurses and other health care providers working in hospital inpatient units across Canada still reported more than 14M overtime hours in 2021–2022, a 50% increase from the previous year (CIHI, 2023a). These numbers continue to be high. For example, the Saskatchewan Union of Nurses reported that RNs worked just under 1.5M hours of overtime in 2023 (Hunter, 2024). The Manitoba Nurses Union also reported that nurses in the public system worked more than $1M hours of overtime in 2023 (May, 2024).

04. In which sectors and/or settings have agencies been used in Canada during each of the past four fiscal years?

To determine the sectors and/or settings where agencies have been used, data were obtained through ATIP/FOI requests, surveys sent to CNEs, surveys completed by nurses working with agencies, interviews and media articles.

In the surveys completed by nurses working with agencies (past and present), participants were asked to identify their specialty practice area and the type of health care facility where they worked. Participants had the option of identifying more than one practice area and type of facility. All responses were then grouped together into similar specialty areas and facility types (Table 11). Ten types of health care facilities were identified, and the five most frequent responses were hospitals, LTC homes, community and home care, rural/remote settings and outposts/nursing stations. Twenty-three specialty areas were identified, and the three most frequent responses were EDs, critical care units and LTC homes (Table 11).

"...it doesn't seem to be as much of an issue with the [LPNs] as it is with the RNs and it extends well beyond the hospital sector. And that's not something we saw before. We didn't see agency being used in long-term care. We see that now. We're seeing public health units using agency nurses. We're seeing industries and clinics. We've also seen, this is a new and developing, certainly, community health clinics, primary health clinics using agency. NPs as well. So, it is really, it's expanded beyond RNs. But it is predominantly RNs." (Nurse leader participant)

In the surveys completed by CNEs and the ATIP/FOI requests, participants were asked to list the top five practice areas in their health authority/organization where nurses from agencies were most frequently required. They were also asked to provide this information for each nursing designation (RNs, LPNs, RPNs and NPs) if available. Three participants provided data for all nurses, RNs and LPNs, but the remaining responses were incomplete as two participants provided no data, four participants provided one to two practice areas for all nurses and other participants provided some data for some of the nursing designations. Additional data were also obtained from one media report (French, 2023) and the Saskatchewan Union of Nurses (2024). All responses were grouped into three groups (all nurses, RNs only and LPNs only). The top five practice areas were then calculated based on the highest percentages of responses for that practice area in each group.

As shown in Table 12, the five most frequently reported practice areas where agencies were used for all nurses during the past four fiscal years were LTC homes, critical care units, EDs, and medical units with four areas – home care, mental health, medical/surgical and surgical – tied for the last area. Acute care was the sector most frequently identified across all responses. In addition to the units listed above, other hospital inpatient areas included obstetrics, pediatrics, medical/surgical, operating rooms, hemodialysis, neurosciences, oncology, surgery, and overflow. Rural and remote settings were also identified as key areas where agencies have been used including nursing stations and nursing outposts. Other areas which were identified by one health authority or hospital, included rehabilitation units, detention centers, and child protective services.

Table 11

Specialty areas and types of health care facilities: surveys completed by nurses working with agencies (past and present)

Type of health care facility	%		%
Hospital	51.6	Clinics	3.1
LTC and resident/personal care home	24.5	Public health unit	0.8
Community and home care	10.5	Corrections, jails	0.8
Rural and remote	4.1	Rehab	0.5
Outposts/nursing station	3.5	Other	0.5
Specialty areas	**%**		**%**
Emergency departments (ED)	22.4	Oncology and renal services	2.3
Critical care	11.6	Pediatrics (includes NICU and PICU)	2.1
LTC and geriatric (includes geri-psych)	10.6	Cardiac services	2.1
Medicine	10.3	Rehab	1.6
Home care and community services	6.0	Palliative	1.4
OR (includes PACU, endoscopy)	4.7	Public health	1.3
Women's services, obstetrics, labour/delivery	4.4	Occupational health	0.4
Medical/surgical	3.7	Neurology	0.4
Mental health and psychiatry	3.1	Infection control	0.4
Rural, remote and northern	3.0	Acute care	0.4
Family medicine/ambulatory care/primary care	3.0	Other	1.9
Surgery	2.9		

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Table 12
Most frequently reported practice areas where nurses from agencies were required by health care facilities

All nurses	RNs	LPNs
Long-term care (n=8) Critical care (n=6) Emergency (n=6) Medical (n=5)	Emergency (n=6) Long-term care (n=5) Medical (n=5)	Long-term care (n=6) Medical (n=4) Rehabilitation (n=4)
Tied: Home care (n=3) Mental health (n=3) Medical/surgical (n=3) Surgery (n=3)	Tied: Mental health (n=3) Rehabilitation (n=3) Surgical (n=3) Critical care (n=3)	Tied: Emergency (n=2) Home care (n=2)

Participants could provide more than one response.
n = number of responses

The five most frequently reported practice areas where RNs were required were EDs, LTC homes and medical units, then four areas (mental health, rehabilitation/transitional care, surgical and critical care) were tied with equal number of responses (Table 12). Again, acute care was the sector most frequently identified. In addition to the units listed above, other areas included obstetrics, pediatrics, neurosciences, float pool, home care and outpatient specialist clinics.

In contrast, the five most frequently reported practice areas where LPNs were required were LTC homes, medical units and rehabilitation units, and then two areas, EDs and home care, were tied with equal number of responses (Table 12). Overall, the acute care was the sector most frequently identified. In addition to the units listed above, other areas included obstetrics, pediatrics, surgical, float, overflow, critical care, palliative care and mental health. One health care facility identified nursing stations and health centres with treatment as the area where NPs were frequently required.

In interviews with four CNEs and managers working at facilities who currently use agencies, participants also identified RNs as the nursing designation most frequently required in medical/surgical, ED, critical care units and LTC homes. LPNs were needed mostly in extended care units. The two urban hospitals reported that agencies were now only used in ED and critical care units in their facilities.

05. What were the hourly agency rates in Canada and which factors affected these rates during each of the past four fiscal years?

Data regarding the hourly rates paid to agencies by health care facilities (hourly agency rates) were obtained through ATIP/FOI requests, surveys sent to CNEs, provincial nursing unions, and media articles. Data regarding the hourly wages paid to nurses by agencies were obtained through surveys and interviews with nurses working with agencies. In a small number of data sources, it was not clear if the reported data referred to the hourly agency rates or the hourly wages paid to nurses by agencies. These data sources are included in the description of the hourly agency rates when other data sources were not available for a health care facility or province. Appendix J provides a detailed summary of the hourly agency rates by jurisdiction with available data and the factors affecting these rates. Data were only available for the past 3 fiscal years.

A health authority in British Columbia reported that their hourly agency rates were regulated by the provincial health authority, while health authorities in Manitoba stated that their rates were set by the province with no negotiation on the rates with agencies. The majority of reported hourly agency rates were for RNs and LPNs with two health authorities reporting hourly agency rates for RPNs, and five health authorities reporting hourly agency rates for NPs. Similar to the previous sections, caution should be used in comparing the actual agency rates across jurisdictions as some hourly agency rates may reflect the base hourly agency rate only without the additional costs, while others may reflect the base hourly agency rate plus the additional costs such as agency fees, travel and accommodation.

Hourly agency rates – RNs

Figure 8 summarizes the hourly agency rates paid by health care facilities for RNs with data provided for 38 health care facilities from different sources. When available, the range of hourly agency rates is also provided. The figure illustrates the wide range of hourly agency rates by health care facilities across Canada, and how the rates for RNs seemed to generally rise as one moved from the Western Provinces to the Eastern Provinces and the Territories. The lowest hourly agency rate was $65/hr reported in Manitoba and the highest rate was $312.4/hr reported in Newfoundland and Labrador. The outliers for higher agency rates were LTC homes in Ontario, two health authorities in Newfoundland and Labrador and one health authority in New Brunswick. In reviewing the range of agency rates, the largest range was in hospitals in Ontario for both general RNs ($53.5 to $260/hr) and specialty RNs ($81.2 to $195/hr), followed by health authority 5 in Quebec ($69.8 to $175/hr).

Hourly wages – RNs

Table 13 provides the average hourly wages reported in the surveys completed by 273 RNs who currently work with agencies (past and present). A wide range of overall hourly wages

Figure 8
Hourly agency rates paid by health care facilities for rns with minimum and maximum rates using available data

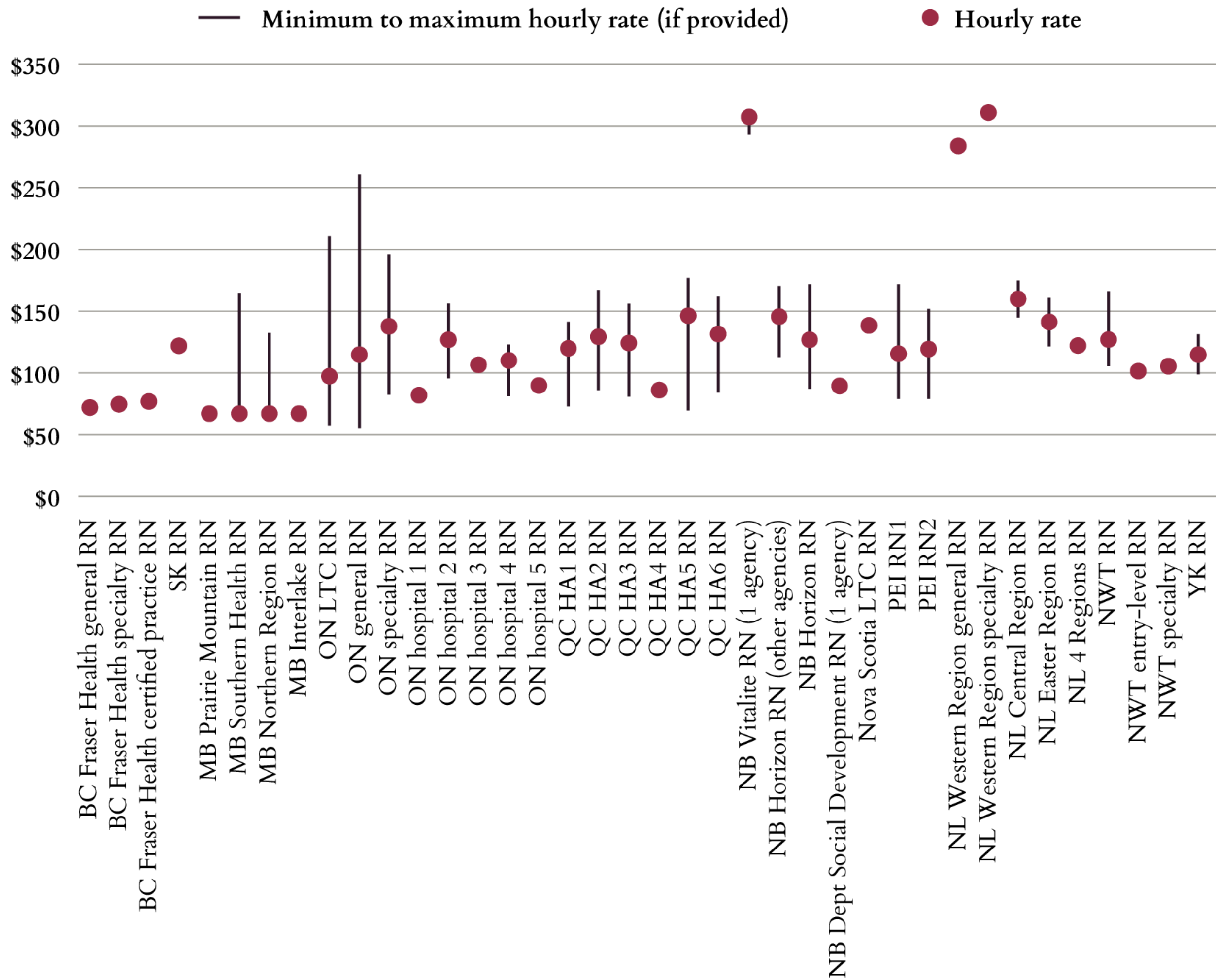


Table 13
Hourly wages: surveys completed by RNs working with agencies (past and present)

	Range	Mean	Standard deviation
Overall RN hourly wage	39.3–300	70.6	25.6
Type of health care facility commonly worked			
Hospital	40–300	75.2	27.7
Outpost/nursing stations	55–82	67.6	10.7
Rural and remote	52–100	67.4	17.4
Community and home care	39.25–165	63	34.5
Long-term care	40–100	60.3	14.4

($39 to $300/hr) were reported with an average close to $71/hr. However, this average varied when the responses were compared across the types of health care facilities where participants worked. As Table 13 shows, RNs working in hospitals reported the highest average and range, while RNs working in LTC homes reported the lowest average. Nurses working in outpost/nursing stations reported the lowest range. The results are not surprising as RNs within hospitals normally report higher hourly wages than nurses in other sectors. While the survey asked participants to identify the province where they were located, the research team learned when contacting interview participants that where they reported being located was not always where they were working, and many worked in more than one province. Therefore, a comparison across the provinces was not made.

"I'd say there's a lot of factors that go into which agency you choose. The thing about private is…they pick and choose what they want to offer you. So, some agencies will say offer you $100 an hour, but others will offer say $70, or one might offer $130 an hour. But some may offer fewer benefits, so to speak, some will offer in-lieu pay, mine doesn't, they just have straight $100 an hour, time and a half for overtime, and that's it. Some agencies will offer, let's say they have a 24/7 hotline, which you can call for staff support, if you need it, those are the larger ones..." (Nurse participant who works with an agency)

Just under 47% of survey participants also reported working for more than one agency with different hourly wages. The differences between wages ranged from $2 to $74/hr with different wages based not only on the agency but also province/territory and location (e.g., northern locations paid more). One participant stated that wages in British Columbia were in the $55 to $62/hr range, New Brunswick in the $90 to $110/hr range and Ontario in the $70 to $100/hr range depending on the agency. Another participant stated wages were $60 to $70/hr for LTC and $90 to $120/hr for ED.

Comparison of hourly agency rates and hourly wages for RNs

While the wide range of hourly wages paid to RNs ($39 to $300/hr) (Table 13) were similar to the wide ranges of hourly agency rates paid to agencies (Figure 8), the bottom range of hourly wages ($39 to $55/hr) was lower than the lowest hourly agency rate of $65/hr reported in Manitoba. However, it was noted that 75% of RN participants reported that the hourly wages were without premiums which may be included in the hourly agency costs reported by the health care facilities. In addition, the hourly agency rates reported by most health care facilities may have included the total rate charged by the agency, whereas the hourly wage reported by RNs who work for agencies were most likely the wages they receive - their hourly paid rate.

Hourly agency rates – LPNs

Figure 9 summarizes the hourly agency rates paid by health care facilities for LPNs with data provided for 20 health care facilities from different sources. When available, the range of hourly agency rates is also provided. The lowest hourly agency rate was $50/hr reported in Manitoba and the highest rate was $306/hr reported in New Brunswick, followed by $124.8/hr in Nova Scotia LTC. Similar to the RN data, the hourly agency rates for LPNs seemed to generally rise as one moved from the Western Provinces to the Eastern Provinces and the Territories. The largest range of agency rates was in Prince Edward Island ($42.9 to $120/hr) followed by Southern Health-Santé Sud in Manitoba ($50 to $125/hr).

Hourly wages – LPNs

Table 14 provides the average hourly wages reported in the surveys completed by 27 LPNs who currently work with agencies (past and present). A wide range of overall hourly wages ($29 to $110/hr) were reported with an average close to $48/hr. However, this average varied when the responses were compared across the types of health care facilities where they commonly worked. As Table 14 shows, LPNs working in hospitals reported the highest average and range, while LPNs working in community and home care reported the lowest average. These results were not surprising as LPNs within hospitals normally have a higher hourly wage than nurses in other sectors. While the survey asked participants to identify the province where they were located, the research team learned when contacting interview participants that where they reported being located was not always where they were working, and many worked in more than one province. Therefore, a comparison across the provinces was not made. Just over 31% of survey participants also reported working for more than one agency with different hourly wages. The differences ranged from approximately $10 to $20/hr.

Comparison of hourly agency rates and hourly wages – LPNs

Similar to the RN results, while the range of hourly wages paid to LPNs ($29 to $110/hr) (Table 14), were similar to the ranges of hourly agency rate paid to agencies (Figure 9), the bottom range of hourly wages ($29 to $35/hr) was much lower than the lowest hourly agency rate of $50/hr reported in Manitoba. However, it was noted that 73% of LPN participants reported that the hourly wages were without premiums which may be included in the hourly agency costs reported by the health care facilities. In addition, the hourly agency rates reported by most health care facilities may have included the total rate charged by the agency, whereas the hourly wages reported by the LPNs who work for agencies were most likely the wages they receive – their hourly paid rate.

Hourly agency rates – RPNs and NPs

Figure 10 summarizes the hourly agency rates paid by health care facilities for RPNs and NPs for five health authorities with two sources reporting RPN rates and five sources reporting NP rates. When available, the range of hourly agency rates is also provided. The hourly agency rate for RPNs was $74.4/hr in British Columbia and $65/hr in Manitoba (range of $65 to $130/hr). The lowest hourly rate for NPs was $82.2/hr in British Columbia, and the highest was $235/hr in Newfoundland and Labrador, followed by Southern Health-Santé Sud in Manitoba ($127.4/hr) who reported a range of $85/hr to $212.5/hr.

Hourly wages – RPNs and NPs

Thirteen NPs working with agencies completed the survey and reported a range of hourly wages from $52 to $120/hr with an average close to $88/hr. Due to the small number, a comparison across types of health care facilities could not be completed. Similar to RN and LPN data, 77% of NP participants reported that the hourly wages were without premiums and that they worked with more than one agency with differences in hourly wages ranging from $3 to $50/hr. The average hourly wage reported by a small number of RPNs was $39/hr.

Figure 9
Hourly agency rates paid by health care facilities for LPNs with minimum and maximum rates using available data

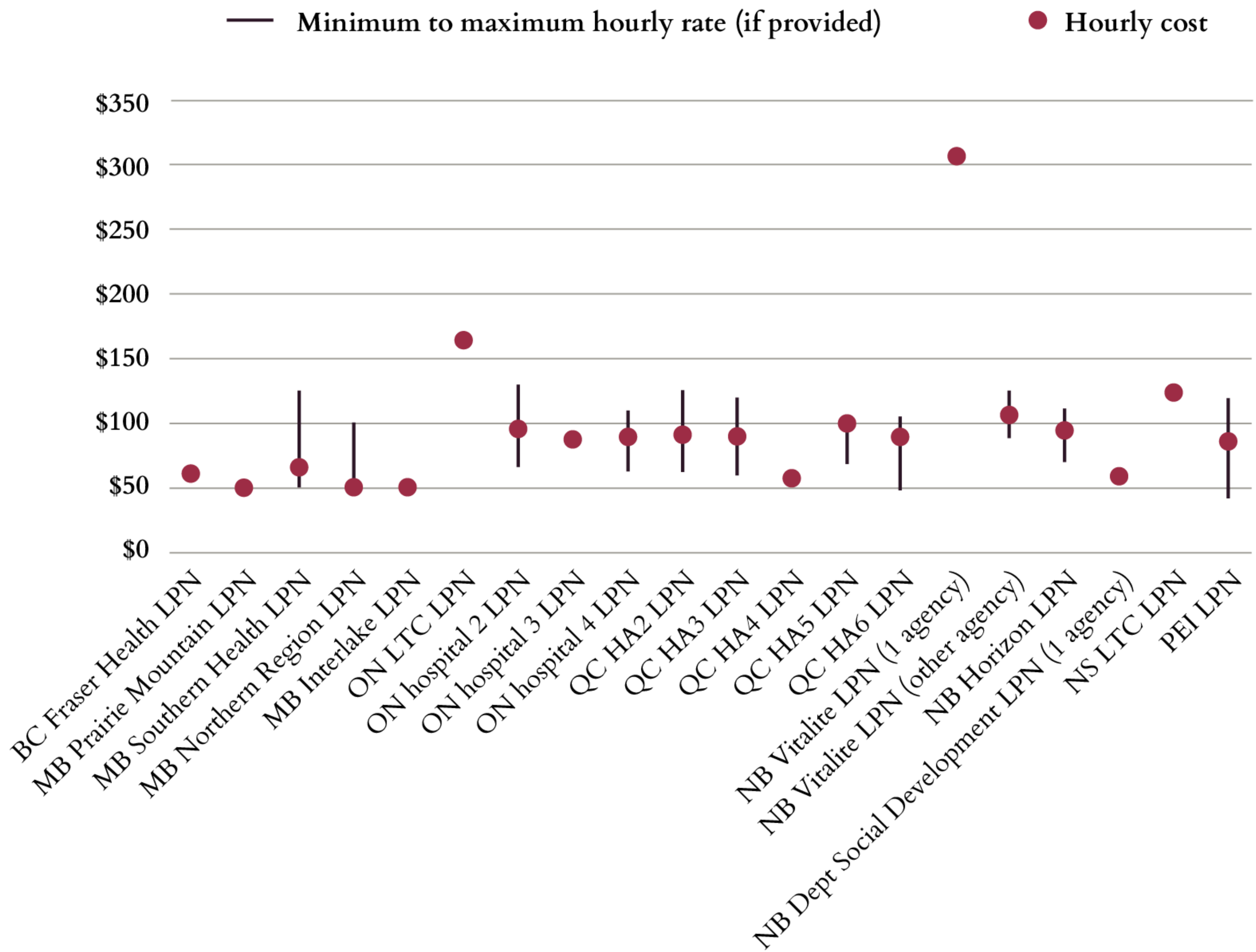


Table 14
Hourly wages: surveys completed by LPNs working with agencies (past and present)

	Range	M	SD
Overall LPN hourly wage	29–110	47.6	15.3
Type of health care facility commonly worked			
Hospital	35–110	53.7	18.3
Long-term care	35–52	44.3	5.2
Community and home care	29–36	32.3	2.9

Comparison of hourly wages between current agency work vs previous agency work

Table 15 compares the average hourly wages reported in the surveys completed by nurses who currently work with agencies and nurses who worked with agencies during the past five years. Most nurses who stopped working with an agency did so in 2023 (44.5%), followed by 2022 (24.8%), 2021 (13.9%), 2024 (9.5%) and 2020 (7.3%). As shown in Table 15, in each of the nursing designations the hourly wage reported by current nurses working with agencies was higher, and with wider ranges, than the wages reported by nurses who previously worked with agencies. The difference for NPs was close to $24/hr, while the difference for RNs was close to $10/hr and $6/hr for LPNs. While the number of participants was small for some of the designations, this is similar to the trend reported earlier with the hourly agency rate increasing over the past four years (Figure 7).

Factors affecting hourly agency rates

To determine the factors (direct and indirect costs) affecting the hourly agency rates paid by health care facilities, data were obtained first through ATIP/FOI requests, surveys sent to CNEs, and media articles. Table 16 provides an overview of the factors reported and identified who pays for the direct costs (e.g., mileage, hotels) or indirect costs (e.g., orientation, identification badges). As shown, most additional direct and indirect costs were covered by the health care facility. The most frequently reported direct costs were related to travel, accommodations, per diems, and higher hourly rates charged for specialty nurses. Onboarding was the most frequently reported indirect cost with costs associated with orientation, obtaining identification badges, employee health, scheduling, etc.

It was noted that there was variation in direct and indirect costs charged by agencies. One hospital in Ontario reported "we have one [agency] that charges a 35% service fee. And two others that charge daily per diems ranging from $40 to $60 per day." Others reported that an agency charged a 25% service fee or $120/day for accommodation. In a survey with 100 LTC homes about their use of staffing agencies over four months, AdvantAge Ontario (2022) reported that rural and northern homes were paying 30% more in costs than urban homes. Table 16 also shows the inconsistencies across what is covered by agencies with some agencies covering costs associated with onboarding and others expecting the health care facility to cover these costs. In addition, costs associated with travel, accommodations and parking were predominantly the responsibility of the health care facility, but in some areas these costs may be covered by the agency or by the individual nurse working with the agency. These differences were reported more frequently in the surveys from Ontario and Quebec then in the ATIP/FOI requests.

Figure 10
Hourly agency rates paid by health care facilities for RPNs and NPs with minimum/maximum rates using available data

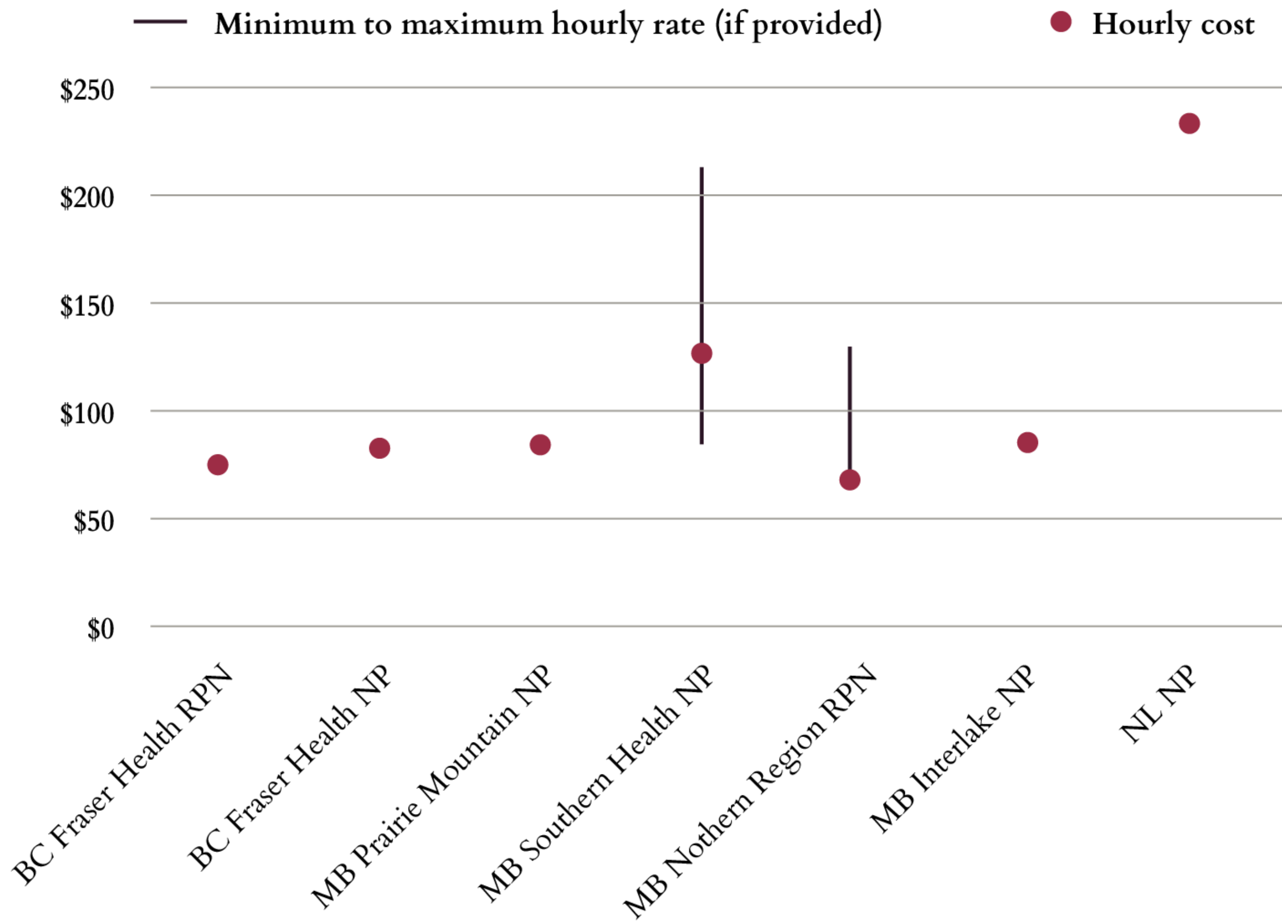


Table 15
Comparison of hourly wages: surveys completed by nurses working with agencies (past and present)

	Range	M	SD
Currently working with agency			
LPN	29–110	47.6	15.3
RN	39.3–300	70.6	25.6
NP	52–120	87.8	29.1
Previously worked with agency			
LPN	28–60	41.6	8.9
RN	15–110	60.5	19.9
NP	53.5–80	63.9	12.6

Table 16
Factors affecting hourly agency rates and who pays for these additional direct or indirect costs

	Paid by		
Direct or indirect costs	Health care facility (n=27)	Agency (n=11)	Individual nurse (n=11)
Travel costs (e.g., mileage, car rental, moving expenses)	25	2	2
Accommodations (actual expense or set amount/day or month)	12	3	2
Per diem (e.g., meals)	8	–	–
Specialty practice (e.g., critical care, ED)	8	–	–
Onboarding (e.g., orientation, badge, employee health, uniform, mask fit test, computer access, scheduling)	8	4	–
Agency service fees/administrative costs (25–35%)	5	–	–
Overtime	4	–	–
Parking	3	3	8
Taxi to and from accommodations to work or airport when moving	3	–	–
Short-notice shifts (e.g., $100/day)	3	–	–
Professional development	2	3	–
Provincial registration to nursing regulator	2	–	–
Rural setting, pay for additional costs	2	–	–
Cellphone	1	–	–
Incentive fee for contractors	1	–	–
Gift cards	1	–	–
Union dues	1	–	–

n = number of data sources
In the surveys and ATIP/FOI requests, participants could provide more than one response, therefore the numbers in each category represent the number of responses, not number of participants.

Costs frequently covered when working with agencies

In the surveys completed by nurses working with agencies, participants identified all costs that were most frequently covered during their work with agencies. The most frequent responses were travel costs (e.g., moving expenses or travel within the role (fuel, mileage), accommodations, parking at the facility and per diem meals, including Uber Eats (Table 17).

Interviews were also completed with nurses working with agencies (past and present), and nurse participants identified similar costs being covered. A nurse participant expanded on the coverage of nursing registration fees by stating "You would have to work 150 hours a year to get your license paid." Another nurse participant identified the requirement to work a pre-determined number of hours to qualify for coverage of registration fees while another nurse participant similarly described needing to work 220 hours in a 28-day period before receiving double time for overtime. Lastly, one nurse participant described how costs such as hotels were also covered if there was a delay during the travel due a cancelled flight.

The information provided in this section illustrates the variation in hourly agency rates paid by health care facilities to agencies and hourly wages paid to nurses by agencies, as well as the complexity of determining the factors that contribute to agency costs: how much is paid to nurses (hourly rate, bonuses, overtime, etc.), what costs are recovered by nurses or agencies and are these actual costs or a set amount/day or month which may be above the actual cost, what additional costs are charged by the agency (service fees), and how much are these costs. The Government of Northwest Territories recently provided a good example of the additional costs associated with agencies as they reported that agencies cost more than $5M in 2022-2023 and a little over $4M in 2023-2024. Travel expenses and per diems alone accounted for more than $1M and accommodations accounted for an additional $1M in these costs during the two fiscal years (Williams, 2024).

Table 17

Costs covered when working with agencies: surveys completed by nurses working with agencies (past and present)

	%
Travel costs (moving expenses or travel within role (gas, mileage)	38.1
Accommodations	34.0
Parking when working	16.2
Per diem meals, including Uber Eats	6.7
Nursing registration fees	1.4
Car rental with fuel	1.2
Taxis/transport/bus pass to and from work, within city	1.1
Education (e.g. certifications)	0.7
Accommodation that includes spouse	0.2
Uniform allowance	0.2
Winter attire, northern allowances	0.1
Internet, cable	0.1

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

"So as soon as I arrive at the airport to leave my home, my travelling was paid for. My accommodations were paid for. My license will be reimbursed based on the number of hours and there was a per diem that's kind of set out the different provinces that you work in. And you are paid a rate that you agree to in the contract. And then you're paid your full way home to your front door. You're given a per diem per week and that kind of works out to what they call your blended rate of pay. Because, an arbitrary number, your per hourly wage will be $45 an hour and then you get paid your annual leave and then you get your weekly per diem. So, they call it a blended rate of $55 an hour."
(Nurse participant who works with an agency)

06. How many regulated nurses have worked with agencies in Canada during the past four fiscal years?

CIHI's HWDB and CNO's nursing data dashboard

As shown in Figure 11, the numbers have fluctuated between 2018 and 2022 but have remained relatively stable. In 2018, 3,359 LPNs reported working with an agency as their primary workplace and this number rose to 3,509 in 2022. In 2021, the number dropped to 3,181 but rose again the following year. In contrast, in 2018, 3,911 RNs reported working with an agency as their primary workplace and this number rose slightly to 4,028 in 2021. Between 2019 and 2020 there was an increase from 3,796 to 4,027. The total for RNs in 2022 was not reported as data for Quebec was not available, which dropped the number significantly. CIHI (2022) also reported that the number of RNs who reported being self-employed or working with an agency rose by 6% in 2022, meaning 867 more were working for agencies or for themselves than the year before. Table 18 provides more details specific to the numbers in each jurisdiction and shows differences across the country with some provinces reporting an increase, others a decrease and others showing stable numbers. The two provinces with the highest numbers are Quebec and Ontario. Interestingly, in Quebec, Saskatchewan, Alberta and British Columbia, more RNs report agencies as their primary workplace, compared to LPNs. However, in the remaining provinces with data available, the numbers are relatively equal, or in the case of Ontario and 2022 in New Brunswick more LPNs report agencies as their primary workplace than RNs. These numbers are in contrast with the number reported by health care facilities which is discussed in the next section.

The numbers for RNs and LPNs should be interpreted with caution for the following reasons: 1) data were not available for every jurisdiction at each data point. RN data was not reported for Manitoba and Prince Edward Island and not reported for Quebec in 2022. LPN data was not reported for Yukon, Northwest Territories or Nunavut, and New Brunswick only reported data for 2022; 2) data may not capture nurses who work with agencies as independent contractors as they may not identify agencies as their primary workplace when completing their annual registration with their nursing regulator; and, 3) data does not capture the number of nurses who work with an agency as a secondary place of employment. In the surveys completed by nurses working with agencies, over 68% worked for both an agency and a public institution simultaneously. When working for an agency, their work status with the public facility was predominantly permanent casual (34.2%), permanent part-time (32.1%) or permanent full-time (23.7%).

Surveys with CNEs, ATIP/FOI requests and media articles

In contrast, when examining the surveys completed by CNEs, ATIP/FOI requests and media articles, the data (Table 19) shows the wide variation and rise in the number of nurses working with agencies in health care authorities or health care facilities across the country. In almost all surveys, RNs were identified as the designation most frequently required, followed by LPNs. However, two hospitals in Ontario and one health authority in Manitoba identified LPNs

as the designation most frequently required. Yukon indicated they only required RNs. Very few RPNs and NPs were identified in the data. In British Columbia, two health authorities reported 50 to 75% of the nursing staff in LTC homes were contracted from agencies, with 100% in one community (Daflos, 2023a). As shown in Table 19, Quebec reported the highest numbers, with one health authority reporting 1,696 nurses.

Scoping review

One Canadian article included in the scoping review examined the number of nurses working with agencies in Ontario. Using the 2011 to 2021 Health Professions Database which is derived from the College of Nurses of Ontario registration records for all RNs and LPNs in the province, Drost et al. (2024) investigated trends in the number of nurses working with agencies, as well as the rate at which previously non-agency employed nurses transitioned to employment in at least one agency job. They reported that the prevalence of RNs and LPNs reporting agency employment was relatively stable from 2011 to 2019 and decreased slightly in 2020 and 2021. However, there was a small increase in transitions from non-agency employment to working at an agency job. Across all years, a higher percentage of LPNs than RNs were working in at least one agency job. These findings are similar to those presented previously in Table 18 which also used data from the College of Nurses of Ontario registration records for the Ontario numbers. Drost et al. (2024) also reported that the mean hours of practice reported for agencies increased during the pandemic. Based on their findings, they concluded that an increase in hours and/or prices charged by agencies may explain the increase in public funding costs.

07. Why are regulated nurses in Canada choosing to work with agencies?

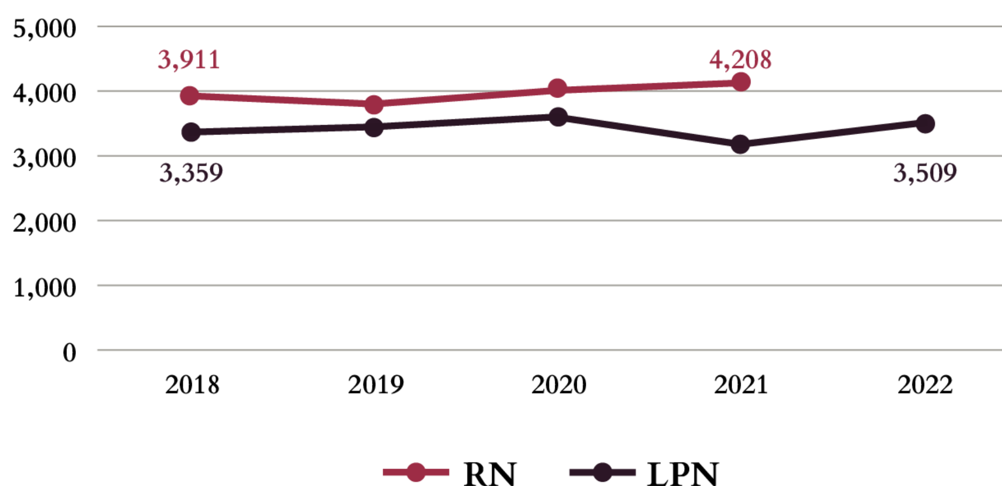
To describe if nurses are considering working with agencies, if they have been recruited and how, and the reasons why they choose to work with agencies, data were obtained from a recent CFNU (2024) survey, surveys with nurses and managers working in health care facilities which use agencies, surveys with nurses who work with agencies (past and present), surveys with pre-graduate nursing students, and the scoping review. In the interviews with nurses who work with agencies (past and present), participants were asked questions to expand on the survey results. This section will summarize all responses.

Considering working with agency

In a survey conducted with 5,595 nurses practicing in Canada, the CFNU (2024) reported that 32% of nurses were interested in agency work, or increasing the agency work they were already doing, while 64% were not interested, and 4% were unsure. Ontario nurses were the most likely to say they were not at all interested (50%) compared to Atlantic (45%), Manitoba, Saskatchewan, Alberta and B.C. nurses (each 43%). Nearly half (48.3%) of new grads were interested in agency work.

Figure 11

Number of nurses reporting agencies as primary workplace 2018-2022: CIHI HWDB and CNO dashboard



RN data for 2022 not included as no data available for Quebec. Numbers reflect nurses who report agencies as primary workplace; may not include those who work as independent contractors or report agencies as a secondary workplace.

Table 18

Number of nurses by jurisdiction reporting agencies as primary workplace, 2018-2022: CIHI HWDB and CNO dashboard

	Year	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC	YT	NWT and NU
RN	2018	15	—	22	26	1,228	2,246	—	31	129	173	†	5
RN	2019	16	—	25	28	1,238	2,083	—	33	141	194	†	†
RN	2020	15	—	18	24	1,416	2,091	—	34	144	231	†	7
RN	2021	19	—	20	21	1,736	1,762	—	44	148	230	†	12
RN	2022	21	—	25	23	—	1,885	—	45	168	279	7	11
LPN	2018	16	5	23	—	575	2,551	30	21	†	130	—	—
LPN	2019	16	—	24	—	578	2,638	37	14	0	118	—	—
LPN	2020	18	0	22	—	683	2,675	47	13	†	125	—	—
LPN	2021	23	†	27	—	868	2,105	—	10	†	136	—	—
LPN	2022	28	0	31	55	851	2,251	75	10	5	175	—	—

— Data is not applicable, does not exist, or is not reported due to data quality issues.
† Cell value is between 1 and 4, they are suppressed in accordance with CIHI's privacy policy.

In the surveys completed in the current study by nurses and managers who work in health care facilities which use agencies, close to 57% of nurses and 42% of managers reported they had considered working with an agency. However, this varied across the age groups as nurses and managers in the younger age groups were more likely to consider working with an agency. For example, 72% of nurses in the 20–29 age group had considered it, compared to 43% in the 50–64 age group. Similarly, 74% of pre-graduate student survey participants reported that they were considering working with an agency in the future while 26% were not (the latter all in the 20–29 age group). When asked how interested they were, 65% of pre-graduate nursing students reported they were somewhat or very interested in working with an agency, 17% were not very interested, and 17% were unsure. Students who were not considering agency work reported that they did not want to leave their current province or

Table 19
Number of regulated nurses working with agencies by region using available data

Region	2020–2021	2021–2022	2022–2023	2023–2024 (mostly Q1-Q3)
British Columbia Fraser Health Authority (2024)	161	494	484	365
British Columbia Vancouver Coastal Health (2024a)	n/a	n/a	243	812 (April–Jan)
Alberta Health Services (French, 2023)	n/a	n/a	341 RNs, LPNs, and health care aides	n/a
Alberta – Covenant Health (French, 2023)	n/a	n/a	35 RNs and LPNs	n/a
Ontario (14 CNE surveys)	0	0	0	0
Ontario (4 CNE surveys)	17	2 to 93	2 to 175	16 to 160
Quebec (3 CNE surveys)	341 to 1,140	476 to 1,484	499 to 1,161	208 to 1,696
New Brunswick (CNE survey)	n/a	n/a	49	403
Nova Scotia (CNE survey)	0	0	0	0
Nova Scotia (Gorman, 2023)	n/a	n/a	n/a	> 350
Health PEI (2024)	n/a	n/a	19 RNs	78: 125 RNs 8 LPNs
Newfoundland and Labrador (Quinn, 2024)	n/a	n/a	n/a	373 to 357
Yukon Health and Social Services (CNE survey)	12	12	24	6

Numbers are based on individuals, not placements.
n/a – not available

community, they liked to be in a specific spot that is stable for their practice, they didn't know enough about agency work, and a lack of pension or benefits. One student participant also reported concerns about agencies "hiring local nurses into positions and there is a huge pay difference that causes a lot of issues for local nurses."

Recruited to work with an agency

Each of the three groups who received study surveys were asked if they had been recruited to work with an agency (Table 20). In each group, the majority of participants reported they had not been recruited which was similar across the age groups when examined. Participants who reported they had been recruited, were asked to identify how they had been approached. Participants could provide more than one response, and all responses were then grouped together into similar recruitment approach. Email was the most frequent approach in each group except students who most frequently reported LinkedIn. Nurses working with agencies (past and present) reported word of mouth from coworkers or friends as the next most frequent approach while other groups reported phone calls, texts and LinkedIn. Lastly, participants were asked if they had been asked to recruit other nurses, or students in the case of pre-graduate students. In each group, the majority reported that they had not been asked to do this, however 63% of nurses who work with agencies (past and present) reported that they had been asked to recruit other nurses. One participant who worked with an agency reported that they received 'referral money' for recruiting other nurses.

Reasons for working with agencies

In the survey with nurses working with agencies (past and present), participants were asked why they started working with agencies. Participants could provide more than one response. Table 21 provides a summary of all the reasons provided. The five most frequent responses were better pay (including overtime) (21%), choice of time off (16.4%), more flexible work hours (14.7%), seeing new towns/cities /facilities (12.9%) and variety of work/practice (10.9%). In the survey with student participants, they were also asked to identify their reasons for considering agency work (Table 21). Their most frequent responses were the same four reasons identified by nurses working with agencies, but student participants also identified housing and/or food allowances (11.1%) as the fifth most frequent response. In the CFNU (2024) study, the main reasons nurses were interested in agency work were similar with better pay (68%), more flexible hours (10%), control over their schedule (8%), choice of time off (4%) and other (9%).

Table 20

Recruitment by agencies, recruitment approaches and request to recruit others using survey responses from four groups of participants, presented separately and combined

	Four groups combined	Nurses working with agencies (past and present)	Managers working in facilities which use agencies	Nurses working in facilities which use agencies	Pre-graduate students
	%	%	%	%	%
Recruited to work for an agency?					
Yes	27.8	28.8	30.1	27.2	22
No	72.2	71.2	69.9	72.8	78
Recruitment approaches*					
Email	35.8	32.7	33.9	38	21.4
Phone call	13.3	15.1	12.5	12.8	7.1
Text	13	7.3	14.3	15.7	14.2
LinkedIn	12.8	8.2	19.6	13.8	28.6
Coworker/friend/word of mouth	8.8	21.6	5.4	2.9	-
WhatsApp	5.4	4.5	7.1	5.6	7.1
Recruitment fair	3.5	3.3	3.6	3.3	14.2
Conference	1.9	2	-	1.8	7.1
Personal research/reaching out	1.5	3.7	-	0.6	-
Indeed website	1.1	-	1.8	1.7	-
Targeted ads/social media	0.8	-	-	1.2	-
Recruiters on unit	0.8	-	1.8	1	-
Instagram	0.5	-	-	0.8	-
Agency owner	0.5	1.6	-	-	-
Facebook Messenger	0.4	-	-	0.6	-
Have you been asked to recruit other nurses/students?					
Yes	40.4	63	7.4	27.5	40
No	59.6	37	21.1	72.5	60

*Participants could provide more than one response for recruitment approaches. Therefore, for each column/group the percentages equal the number of responses for each approach divided by total number of responses for all approaches listed.

Table 21
Reasons for starting to work or considering working with agencies: surveys completed by nurses working with agencies (past and present) and pre-graduate students

	Nurses working with agencies (past and present)	Pre-graduate students
	%	%
Better pay (including overtime)	21.0	22.2
Choice of time off	16.4	15.9
More flexible work hours	14.7	15.9
Seeing new towns/cities/facilities	12.9	14.3
Variety of work/practice	10.9	7.9
Working conditions in public system	9.7	7.9
Housing and/or food allowances	7.8	11.1
It was the work available	3.6	4.8
Work-life balance	0.6	-
Avoid poor treatment/burnout and seek respect	0.5	-
Avoid restrictions due to vaccine mandates and unions	0.5	-
Avoid politics and issues with management	0.4	-
Self-employed tax break	0.4	-
Personal and professional growth: autonomy, extra training	0.3	-
Opportunity to work with specific populations	0.3	-

Participants could provide more than one response. Therefore, for each column/group the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Table 22
Main reason for working with agencies: surveys completed by nurses working with agencies (past and present)

	%
What was the main reason?	
Pay and affordability	46
Work-life balance, schedules and flexibility	21.7
Travel, adventure, seeing new places	12.3
Working conditions/environment (e.g., staffing, disrespect)	8.2
Work or gain experience in a specific practice area	3.5
Burnout, self-care or mental health	2.9
Only work available/difficulty finding work	2.6
Avoid restrictions due to vaccine mandates and unions	1.5
Perks (e.g., paid accommodation, mileage)	1.5

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Main reason

When nurses who work with agencies (past and present) were asked to identify the main reason they chose to work with agencies, the most frequent responses were better pay (46%) followed by work-life balance, schedules and flexibility (22%). Table 22 outlines the remaining main reasons for working with agencies.

Scoping review

Results from the scoping review identified similar reasons for working with an agency, including better pay, flexibility and work-life balance, however working conditions were discussed in four studies as well as career development.

1. **Better pay**
   Better pay was identified in six studies, particularly by nurses working in hospitals (De Ruyter, 2007; Hult et al., 2022; Manias et al., 2003a; Mazurenko et al., 2015; Peerson et al., 2002; Rispel et al., 2015).

2. **Flexibility**
   Nurses working for agencies described greater schedule flexibility compared to permanent positions (De Ruyter, 2007; Peerson et al., 2002; Rispel et al., 2015), more autonomy in shift planning (Hult et al., 2022), greater flexibility in working hours compared to rigid hospital routines (Ronnie, 2020), and the ability to choose shifts and no longer be involved with schedule disagreements with co-workers (Simpson & Simpson, 2019).

3. **Work-life balance/control over schedule**
   Nurses working for agencies identified that agency work allowed them to structure work duties around family duties (De Ruyter, 2007), childcare (Simpson & Simpson, 2019) and personal commitments (Manias et al., 2003a), and was a relief from work overload in hospitals (Hult et al., 2022) which contributed to a better work-life balance.

4. **Working conditions**
   This included the lack of respect in permanent work and office politics (De Ruyter, 2007; Hult et al., 2022; Manias et al., 2003a; Simpson & Simpson, 2019).

Career development was also discussed, including the ability to pursue other areas of interest, consolidate skills (Manias et al., 2003a), broaden career horizons to provide higher quality care (De Ruyter (2007), and gain skills or take on additional skills (Rispel et al., 2015; Simpson & Simpson, 2019). Lastly, De Ruyter (2007) identified two additional reasons, including agency work being a means to extended periods of travel and a possible route for leaving the nursing workforce entirely.

Interviews

Below are the perspectives of six interview participants who work with agencies (past and present) as they expand on the main reasons identified in the surveys. Some participants focused more on working conditions and issues with the public system.

Better pay

> *"I make triple what I did working as a staff nurse, I have guaranteed overtime, I can support my lifestyle goals, investments, I can support a future that I want. And when I was in my union job, I literally filed a grievance over [a small amount of money], I felt like I was pinching pennies, micromanaging every single premium, checking my pay stubs to make sure that I got the right ones added." "And kind of that [small amount of money] moment was the straw that broke the camel's back, like why am I fighting for pennies right now."*

Flexibility

> *"It's not really hired, but I'm a private contractor and my own business. But I'm on the roster for like five different companies, and part of that is for that flexibility of being able to go. And that hiring process is a lot less intensive, bureaucratic, time-consuming….it can take you a month before you're in that position or a month before they tell you that you're not hired. That might go to that flexibility piece that it's just like I'm on five different rosters and anytime they have hundreds of different hospitals, and I can go to any one of them at any time. And I don't have to re-interview because it's a different manager from a different unit."*

> *"I have a lot of options. I could have gone to more northern and stuff like that but because of my unique situation with family and stuff, I choose I want to have this 450-kilometre radius maximum currently if I'm not going with my family. And that's another actual good point in terms of benefits. When I got my New Brunswick license, I was about to go last summer to New Brunswick, and they were going to give me an electric vehicle, or they were trying to find me a van because I was like, "I need to bring my family with me if I'm going that far away." And they were going to find me a two-bedroom place."*

Concerns with the public health care system

One participant discussed how they retired from a role they had been in for more than two decades and asked to work casual within their health authority because they didn't want to stop working altogether. After their request was declined, they started working for an agency.

> *"… I was ready to leave the job but I wasn't ready to not work. And after my retirement, the health authority declined any casual work." "I kept the HR response in a file on my computer just to say that wow, you just gave away [X] years of experience. And it was pre-pandemic and once the pandemic started and they were looking and a lot of my co-workers who had retired went back with our health authority. And I thought no, you turned me down once, I'm not interested."*

Another participant discussed the frustration of seeing how baby boomers have been treated in the public system.

"I know they're coming up with these mentoring projects and everything else but… [they]… let all the baby boomers walk away. And we warned you it was going to happen, and you did not listen to us. So don't come crying to us now when you've reached the stage where we need the senior nurses. Well, where were you when I still needed to work? You weren't there for me. So, I think that's in every business and I think society has totally disrespected experienced employees and the three generations in the workforce… it's a very difficult thing to do [a] 365 of it."

"If the working conditions were a lot better then people aren't going to leave, first of all, and then you can probably pay them – you don't have to pay them as much if the working conditions are better, right? There won't be such a demand for that upward pressure on remuneration. But if the working conditions are going to stay similar, then people are going to leave the system or and get paid or there may be a lot of upheaval in the unions, whatever the people who are working in the public system to get paid. They're just going to leave and get paid better."

Avoiding office politics

One participant discussed how they chose to work with agencies because they were able to focus on the nursing aspect of the role which was the reason they went into nursing, and not be drawn into other aspects that are beyond nursing that is more administrative or more corporate.

"I think by far the first reason would be the avoidance of hospital politics. As an agency nurse I get to show up to my job, do my job, leave, and not have any other expectations of me. Which is strange to say because that's what a job should be." "But by and large I think that's why returning to the public sector has no interest to me – because regardless of the money, regardless of the time off, regardless of every other benefit, the one that's almost invaluable is just getting to treat nursing like a job."

Ability to take vacation

"And in terms of time off, because I'm junior staff, I don't get my vacation approved, because the more senior staff will get it before me. So, having paid time off isn't actually a benefit for me to be staff. While as an agency nurse, I can negotiate my contract length, I can ask for time off. I can even ask for time off within a contract and have those as stipulations."

08. What are nurses' experiences working with agencies in Canada?

In the surveys and interviews with nurses who work with agencies (past and present), participants were asked questions about their role and experiences as well as the advantages and disadvantages of working with agencies and strategies or initiatives which would influence their return to public system. This section will summarize those responses.

Length of time working with agency and work status

Just over 66% of participants reported currently working for an agency, while just under 34% previously worked for an agency. Participants currently working with an agency reported working there for an average of three and half years (M=3.5, SD=4.0, range 0.8 to 25 years) and they worked with approximately 2 agencies (M=2.2, SD=1.5, range 1 to 14). Participants who previously worked with an agency reported working there for an average just over 2 years (M=2.3, SD=3.0, range 0.8 to 20.5 years) and they worked for 1 to 2 agencies (M=1.5, SD=0.8, range 1 to 5). In both groups, most participants reported that their work status with an agency was casual/contract-based (select own hours to work or worked on a contract basis with full-time hours, 48.3%), full-time (31.4%) or part-time (12.2%).

Working in the public system

Close to 92% reported that they worked in the public system prior to working with an agency. Among those who reported they had worked in the public system, the average length of time they spent working at a public facility prior to starting at an agency was 7 years (M=7.0, SD=7.4, range 0 to 41). In the public facility, 49% had held permanent full-time positions, while 32% had held permanent part-time positions and 13% had held permanent casual positions. The remaining participants had held temporary/contract positions with full-time (2.3%), casual (1.9%), and part-time (0.9%) hours. Fifty-seven percent did not resign from these positions once working with an agency while 43 % did resign from the public facility. When asked if they had returned to work in the same public facility as an agency nurse, 87% reported they did not return while 13% did return. Over 68% worked for both an agency and the public system simultaneously, with hospitals and LTC homes being the main type of facilities where they worked as an agency nurse and as an employee in the public system. When working for an agency, their work status with the public facility was predominantly permanent casual (34.2%), permanent part-time (32.1%) or permanent full-time (23.7%).

Type of shifts

When working for an agency (past and present), close to 62% of participants reported working mostly the day shift, while 30.6% reported working mostly the night shift and 7.6% the evening shift. The most common shift length was 12 hours (62.5%) or 8 hours (30.5%), however 2.8% reported that the shift length varied depending on facility needs, and others reported 10-hour

shifts (1.4%) or shifts less than 8 hours (0.9%). Nurses working in outpost or nursing stations reported being on call standby for 24 hours (2.1%).

Length of time in same facility

Just over 73% of nurses who work with agencies (past and present) reported that they were normally scheduled in the same facilities consistently, while 27% reported they were not. Participants working in community and home care facilities reported the highest level of consistency (80.5%) while participants working in outposts/nursing stations reported the lowest level of consistency (61.5%). Overall, 30% of participants reported that they were normally in the same facility for one to 3 months, with 20% of participants reporting they were only in the same facility for 4 weeks or less. Eleven percent reported that the length varied depending on the contract and facility's needs, and just over 4% reported that it was the nurse's choice with how long they were in each facility. The remaining responses ranged from four months to greater than three years in the same facility (Table 23).

When length of time in the same facility was examined by the most common types of facilities, participants working in community and home care reported working in the same facility for greater than three years (56%). Participants in outpost/nursing stations most frequently reported 4 weeks or less (52.4%), as did participants in rural and remote facilities (30.4%). Participants in LTC homes most frequently reported one to 3 months (10.6%), as did participants in hospitals (28.7%).

While 87% of survey participants who work with agencies (past and present) reported they were scheduled in the same practice area consistently, 30% also reported going to different areas or floors regularly. Over 83% reported having the option of choosing the types of units and facilities where they worked while 17% did not have the option. The most common practice areas were LTC (23.5%), EDs (22.7%), multiple areas (14.3%), critical care (10.1%) and medicine (7.9%).

Table 23
Length of time normally in same facility: surveys completed by nurses working with agencies (past and present)

	%
1-3 months	30.1
4 weeks or less	20.2
Varied depending on contract/facility	11
>3 years	9.6
7-12 months	9.1
4-6 months	8.8
Choice of nurse	4.4
13-24 months	3.9
Over 2 years	2.9

"When I do a contract, it can be anywhere from four weeks, I think the longest I went was 10 weeks. I love the six weeks, it's just the perfect amount of time." (Nurse participant who works with an agency)

"Normally six to eight weeks is the normal time. I've done as short as four and as long as three months to a specific contract." (Nurse participant who works with an agency)

"I get to put forward what I would prefer. But that is no means guaranteed. I do understand with other specialized nurses that that is a much easier thing to do, especially when it comes to labour and delivery. That's exclusively what they go for and such." (Nurse participant who works with an agency)

Table 24
Orientation or onboarding: surveys completed by nurses working with agencies (past and present)

	%
Did you receive orientation or onboarding when starting to work at new facility?	
Yes	87.4
No	12.6
If yes, please describe*	
Corporate or unit orientation with varying length	34.8
Shadow or buddy shifts	33.6
Combination of education modules, orientation sessions and/or buddy shifts	10.3
Education modules – often online	7.5
Computer training	5.6
Minimal	4.4
Some places yes, some none	2
Go in before shift starts to become familiar with unit	1.8

*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Orientation or onboarding

As outlined in Table 24, when starting to work at a new facility, 87.4% of participants reported receiving orientation or onboarding. When asked to describe the orientation, participants could provide more than one response. The most frequent responses were corporate/unit orientation of varying lengths (34.8%) and having shadow/buddy shifts with permanent nurses in facility (33.6%). Other responses included a combination of education modules, orientation sessions and/or buddy shifts (10.3%), education modules only (often online) (7.5%) and computer training only (5.6%). In contrast, close to 13% of responses indicated that participants did not receive any orientation or onboarding, while 4.4% received minimal orientation, 2% received in some facilities but not others, and 1.8% reported going in before shift started to become familiar with the unit.

"…they don't have any control of sending me anywhere. I decide what I want to do and when I want to do it. And so, for me, I only work emerg, and, like I said, I'm not opposed to working an emerg/acute split, although I will make it known that I don't want to work on inpatients very much. So, I only get sent to emerg because that's the only thing that I give them an option to put me in." (Nurse participant who works with an agency)

Length of orientation

When participants who reported receiving orientation were asked about the length of time they had been provided at a new facility, participants either reported hours if the orientation was less than one day or days if it was one day or more. Seventy-seven participants reported an average of 2 hours (M=1.9, SD=1.6) with a range of 0.3 to 8 hours, while 417 participants reported an average of 3 days (M=3.3, SD=4.3) with a range of 1 day to 40 days. Overall, 85% of participants reported feeling comfortable working in the practice area after orientation/onboarding, while 15% did not feel comfortable.

Benefits

Nurses working with agencies (past and present) were asked about benefits (e.g., dental, medical, pension) offered or provided by agencies. Seventy-nine percent of participants reported that they did not have the option of receiving benefits. Participants who reported receiving benefits were then asked to describe the benefits and could provide more than response. Of the 21% who did have the option of receiving benefits, the most frequent responses were dental (25.5%), medical (24.5%), sick time (8.2%), all benefits except pension (8.2%) and group/full benefits (7.6%) (Table 25).

Missed benefits of being a member of a union

In the surveys completed by nurses working with agencies (past and present), just over 26% reported that they missed the benefits of being a member of a union. Participants who missed the benefits of the union were then asked to describe what they missed and could provide more than one response. The most frequent responses were the union's advocacy, protection and security (35.7%), benefits, vacation and paid sick time (35%), pensions (14.3%), and premiums (e.g., shortchange shifts, holidays, shift work) (7.9%) (Table 26).

"No, I don't receive any benefits from – I know some people who work for agencies, they're like employees of the agency, and in those cases, some of those people get benefits…" (Nurse participant who works with an agency)

Table 25

Description of benefits offered by agencies: surveys completed by nurses working with agencies (past and present) who reported having the option of receiving benefits

	%
Dental	25.5
Medical	24.5
Sick time	8.2
All benefits except pension	8.2
Group/full benefits	7.6
Pension	4.3
Purchased separately, paid by individual	5.4
Can opt in if full-time hours after amount of time	3.3
Optical	2.7
Life insurance	2.2
Registered retirement savings plan	2.2
Vacation	1.6
Depends on agency	1.6
Blue Cross	1.1
Physiotherapy	1.1
Purchase separately, partially funded by agency	0.5
Accidental death and dismemberment	0.5
Massage	0.5
Workers' compensation	0.5

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Reasons for stopping work with an agency

The majority of participants who had stopped working for an agency did so in 2023 (44.5%), followed by 2022 (24.8%), 2021 (13.9%), 2024 (9.5%) and 2020 (7.3%). The five most frequent responses for stopping were transitioning to another job (job of choice or full-time job) (18%), personal reasons (moved, family, retired) (17.6%), concerns working for agencies (lack of oversight, professional liability, lack of job security, unsafe role) (10.2%), tired of travelling (9.8%) and end of contract (no renewal or role ended post-COVID) (9.3%) (Table 27).

When asked if they had returned to working in the public system after leaving their work with an agency, close to 89% reported they had returned. Just over 11% reported they had not returned because of poor working conditions (31.6%), working outside the public system (e.g., federal, non-profit) (21%) or they were burned out (15.8%).

Table 26
Missed benefits of union: surveys completed by nurses working with agencies (past and present)

	%
Protection, advocacy, security	35.7
Benefits, vacation, sick time	35
Pension	14.3
Premiums – shortchange shifts, holidays, shifts	7.9
Overtime	2.9
Pay increments	1.4
Training opportunities	1.4
Building seniority	0.7
Set schedules/rotations	0.7

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Table 27
Reasons for stopping work with an agency: survey completed by nurses who previously worked with agencies

	%
Transitioned to another job (job of choice or full-time)	18
Personal reasons (moved, family, retired)	17.6
Concerns working for agencies (lack of oversight, professional liability, lack of job security, role unsafe)	10.2
Tired of travel	9.8
End of contract (no renewal or role ended post-COVID)	9.3
Wanted better benefits (e.g., pension) and union support	8.3
Schedule (too many or too few hours; lack of structure)	6.8
Work environment (poor experience, workload, lack of training)	5.8
Low salary (especially post-COVID)	5.4
Wanted better work-life balance, burned out	4.4
Went back to school or finished school	4.4

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Advantages of working with an agency

In the interviews with nurses who work with agencies (past and present), participants were asked to identify the advantages of working with an agency. They identified seven main areas: higher pay, avoiding workplace politics and administrative burden, opportunities to network, flexibility in choosing schedule, having new nursing experiences and having different opportunities. Below are quotes from the interviews to illustrate these areas.

> *"You get to travel, see new places, meet new people. Freedom. You get freedom. You can work as hard or as many hours as you want. You can – especially if you start to get yourself known in some of these facilities – you can kind of network and break the no-compete rule. Because I know some nurses have done that but I don't believe in that so I didn't do it. But I know some nurses have done that. Or, you know, you wait that one year that's stated within your contract from – and then you just talk specifically. I've actually had – some of the bedside nurses I was working with at some of these – at some of these sites that had reached out to me personally because they had now become the director of care. And they've reached out personally to me to see if I would come, and that they would put me up; they would do, like, the whole thing. But cutting out the middleman."*

> *"Advantages, the biggest one would definitely be the wage. You could kind of set your wage wherever you wanted it. They had a little bit of like a scale but for the most part, if you negotiated and said like I have this experience and this course you could increase your wage a bit. So that was definitely a huge advantage. Another advantage was just kind of the way they took care of their nurses. Like I didn't feel – I always had somebody to contact. Things were always put in place for me, like going to a new area. So it was just good the way they helped set you up."*

> *"Working for the agency has been positive because you're constantly learning, if your mind is open, to different ways of growing your own practice. Being a senior nurse, you also have the ability to mentor some new nurses. I just keep thinking somebody is on orientation, why are you putting them with me? Because you have the knowledge and the skills. I think that's something that… the employers of the provincial governments are missing the mentoring aspect of senior nurses and they're just letting them go out of the system. And there is nobody to mentor or bring along the young ones. And I think the young ones get overwhelmed because they don't have the experience I had."*

> *"So I would definitely bring it back to… not dealing with the administrative bureaucracy thing. That would be clear number one for me. The second one would be the consistent time off, blocks of time off, however you want to categorize that one, of consistently being able to rest and not permanently go back to work consistently and stuff like that is a huge draw. Three would just be the improved pay."*

Disadvantages of working with an agency

Next, the interview participants were asked to identify the disadvantages of working with an agency. They identified six main areas: uncertainty of where you are working, concerns if

putting license at risk, isolation, no benefits, challenges with taxes and portrayal in the media. Below are quotes from the interviews to illustrate each of these areas.

> *"So, yeah, the disadvantage specific to travel nursing is you don't know where you're working, you don't know who you're working with – and that's huge – you don't know whether or not you're going to be putting your license at risk… you're going in into an entire unknown. You have no idea if you're going to end up in a situation where you've got to choose between your license and somebody's life. Because you don't know the systems."*

> *"If you are a very social person, it's going to be a hard life being a travel nurse because a lot of your life is work and home by yourself. So it takes a while to develop relationships. And I think that's a disadvantage that unless you're mature and comfortable with yourself. I want to [also] say having to keep quiet and accepting of different ways of doing things. And again, I think that comes with experience and maturity. I'm not really sure how the young travel nurses are actually coping."*

> *"I think the only one that comes to mind would be sense of security on a unit in terms of – I know that I've worked with multiple nurses who said they can't do that type of thing because the first two weeks of any job is the hardest for them where you don't know where anything is, you have to ask. And, I hate that too. I'm shocked I can do travel nursing because of how much I hate that. But absolutely that's the biggest disadvantage of kind of feeling like you are a bit of a burden when you first come to a unit, even though you are there to help."*

> *"Well, there's kind of the social thing around people not really understanding the wage and not maybe liking that. For the agency I worked with particularly, I was an independent contractor. So, they did not remit any taxes for me. I haven't done my tax return yet so I don't know if it will be a disadvantage but kind of a disadvantage."*

> *"For someone coming into it, it might be like, "Oh, I don't want to have to save my own taxes and make sure I put enough CPP, EI, and tax money away." And not having benefits is, of course, you have to pay privately for your benefits. Which the one thing I'd say the public system can, at least in [X], with [the union] and stuff like that, we get amazing benefits." "Even if you wanted to pay all the money in the world, they don't offer it to you. If I just wanted to buy it myself, they won't allow that. That's one thing that they can do, and that's the one negative of the private nursing that I've done that don't offer any benefits. That's definitely a negative."*

> *"I think I'm old enough to realize that the compensation that you receive as a travel nurse, when you have no sick leave, you have no benefits, you have no holidays, you have no nothing. And I really and truly think the media in their sensationalism of travel nurses have missed this whole little box of what your life is like as a travel nurse. And when you put all the factors together, the money is practically the same. And that's something that really bothers me when I read the media in looking at giving bad names to travel nurses and gouging governments and everything." "Well, you know what? We're away from our home. We have no benefits. We work or we don't get paid. We're not – our families are left behind. The fallacy of family members travelling with you, yes, your partner can travel with you at their own expense. So, it's not a glamorous place. You have to be happy with being alone in a new city and not knowing anybody. So, when you're looking at are you being compensated fairly? I think you are. It's those intangibles that the media is missing out on your being compensated for."*

Strategies or initiatives which would influence return to public system

In the surveys with nurses working with agencies (past and present), participants were asked to identify the strategies or initiatives that might influence their return to the public system (Table 28). Participants could provide more than one response. Thirteen percent of the responses indicated that no strategies or initiatives would influence the return of participants. Of the remaining responses, the most frequently reported were financial incentives, including better compensation and incentives such as extra pay for working in specialty areas, a signing bonus, free parking or coffee or reduction in the annual registration fees paid to the regulatory College (34%) and improving work conditions (11.5%) with better staffing, improved workloads with nurse-to-patient ratios, creating safe work environments by having zero tolerance for violence and better support from human resources for eliminating toxic

Table 28

Strategies or initiatives which would influence return to public system: surveys completed by nurses working with agencies (past and present)

	%
Financial: better compensation, pay incentives for specialty areas, signing bonus, free parking, cheaper/reimbursed annual registration to regulator	34.1
Will never return to public system – needs complete overhaul	12.9
Work conditions: better staffing, workload, nurse-to-patient ratios, zero tolerance for violence, better human resources to reduce toxic behaviours	11.5
Flexible schedules (including self-scheduling), work/life balance, lower EFTs	10.9
Better benefits, per diems, premiums, pension, tax breaks, more vacation days	6.6
Management: better support, reduce bureaucracy, reduce executive leadership	4.9
Respect: feel valued, listened to, appreciated	3.3
Flexible vacations, granting vacations or leaves	3.3
Flexible job opportunities: working in other units, varied opportunities for senior nurses, opportunities to travel	2.4
Unions: change structure, optional fees, better support, more transparency	2.2
Retention initiatives, including bonus for staying	2.1
Stop mandates, such as overtime and vaccine requirements	2.1
Paid professional development opportunities	1.9
Provincial float pool/locum opportunities, partnerships with other hospitals	0.8
Mental health supports, health/wellness funds, wellness days	0.6
Reinstate seniority when returning	0.5

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

behaviours. Flexibility was mentioned in three of the identified strategies/initiatives including flexible schedules (10.9%), flexible vacations (3.3%) and flexible job opportunities (2.4%). Other strategies/initiatives within the top 10 responses included better benefits, per diems, etc. (6.6%), more supportive management with less bureaucracy (4.9%), feeling respected, valued and appreciated (3.3%), changing the structure of unions with better support, more transparency and optional fees (2.2%), and clear retention initiatives including a retention bonus (2.1%). Retention initiatives could include many strategies/initiatives also identified.

In the interviews with nurses working with agencies (past and present), participants were also asked about strategies and initiatives that would influence a return to the public system. They identified strategies and initiatives similar to the survey participants, including increase in pay (better pay scales), having flexibility in scheduling and compensation packages, better working conditions, recognition and appreciation programs, improving the culture, and providing more incentive for increasing education or certifications by providing higher pay for nurses working in higher acuity areas. Below are quotes from the interviews to illustrate each of these areas.

Flexibility in scheduling and compensation packages

> *"What would get me to go back to work here at home? The ability for flexible scheduling and not having a phone call at 6:45 every single morning saying can you work? Can you work? Can you work? This is what I'm willing to work and that's it. Do not contact."*

> *"We used to do self-scheduling at our hospital, and I think that it went really really well. And we don't do that anymore and people hate it. But yeah, the ability to choose my schedule more would definitely have a huge impact. Yeah, and just having more – more individualized compensation plans, you know. Like we have our union agreements where we all just get one thing and I think that that's amazing. It's very fair. But it also – it doesn't always meet the needs of everyone. So, thinking more innovatively around how we can offer different things based on what different people need."*

Better working conditions

> *"I think universally when we talk about the profession I always end up with the image of a sinking ship in my head. And at this point trying to find or pick a hospital to be permanent in and maybe build up some seniority, or maybe settle down and have a family and ever doing that just feels like, well, which sinking ship do I want to go down with? Because it doesn't feel like, oh I can find a good one that's staying afloat. Or I can – you know what I mean? It feels like it's almost universally every hospital's losing this battle. And it feels almost like gaslighting when we see our regulatory bodies and governments say they are doing these things to try and fix the problem that are very obviously not going to fix the problem. They might ease the problem. They might make the problem less worse. But will never actually – like, there's no world where I see in the future where we have a surplus of nurses."*

Recognition and appreciation programs and improving culture

"One of the biggest things I think is respect for the experience and knowledge."

"Things that made me return to like the public system, they were offering different incentives at my hospital. Like all – all overtime was double time. Floating to different floors was double time, which as a casual employee I float a lot, so my wage went up dramatically when I came back. Also just different recognition programs. The hospital I work for right now, they've been doing a lot of different employee appreciation programs and I think the – the culture at the hospital has dramatically improved because of that. When I go to work now, people are happy to be there. They're appreciative of their co-workers and it's a good environment to be in. So that's the strategies that brought me back and away from private."

More incentives to increase education

"And I'm not much for this system of where you just put in your time, and you have more value because you put in your time. I think the private system has it right in terms of the people who get paid the most in this system, ICU, emerg. And it depends on the demand."

09. What are nursing students' perceptions of working with agencies in the future?

In the surveys with pre-graduate nursing students, participants were asked about their perception of working with agencies in the future. This section will summarize those responses.

Plans to stay in Canada or province/territory

Ninety-one percent reported they were planning on staying in Canada to work upon graduation, while 8.7% reported they were planning on leaving Canada. One participant lived in a border city and planned on commuting, while another participant reported there was no full-time work in their province with larger signing bonuses and higher wages elsewhere. When asked if they were planning on staying in their province or territory, 87% reported yes, while 13% reported plans of leaving.

Heard about agencies

Eighty-seven percent of student participants reported they had heard about agency or travel nursing, while 13% said they had not. When asked how they had heard about it, the most frequent responses were social media/online/media (31%), followed by other health care providers (19%), agency nurses (15%), instructors or topic at school (12%), friends (12%) and personal research (8%).

Considering agency work

Sixty-one percent of student participants reported they would work full-time with an agency, while 78% reported they would work part-time. Ninety-one percent reported they would consider working with an agency as a second job. If working with an agency part-time or as a second job, 79% reported that they would work with both the agency and a health care facility within the public system because this offered a variety of practice areas, they would have control over their work environment, gain experience and receive benefits. Twenty-one percent reported they would work only with an agency due to better working conditions, better pay and flexibility in hours.

Looking for a nursing job and graduation

When asked about the characteristics that are most important to them when looking for a nursing job after graduation, 23% of the responses reported both transition programs and mentorship as well as location of facility as the top characteristics. Additional responses included both work environments (supportive, team morale) or salary/wage (18%), followed by professional development, workload or scheduling (5%). Time spent with patients and working in an acute care facility were also identified. When asked if they had any concerns about support during their early practice as a new graduate, 65% said they did not have any concerns, while 35% of the responses being concerned about 1) lack of orientation, formal support or training provided, which could lead to being placed in unsafe situations, and 2) financial/work availability. Close to 59% were considering working for agencies right after graduation, while 41% were not because it is better to have practice experience in one place first.

Student's opinions about the benefits of union

Overall, 68% of student participants had a positive opinion about the benefit of unions in their future workplaces, while 16% had a negative opinion, 10% thought there were both positive and negative benefits or were unsure. When asked to describe the benefits, most responses reported that unions were there for support when needed, provided nurses with a voice for better pay and safer work environments, employment security and benefits.

Careers in five years

When asked how they envisioned their careers in five years, 35% of the responses reported continuing their education with a master's degree, working as a nurse practitioner, obtaining their baccalaureate degree and working as RN (participants currently in an LPN program) or going to medical school. Thirteen percent reported wanting to work privately in their own practice or as a travel nurse. The remaining participants discussed moving into specific areas such as ED, critical care, operating room, perinatal nursing or working in an Indigenous community. When discussing how they think their career will progress, participants' responses discussed the failing health care system that currently exists as "publicly funded roles are

fraught as there is a lack of ability to give health care at a way that is sustainable" and the need to improve the system. As a long-term option, many participants preferred staying in the public health care system but as one participant stated, "it all depends on the way I will be welcomed by the people of the institution." Others reported not seeing themselves working in the public health care system as it is.

10. Why are health care facilities in Canada using agencies?

In the surveys with CNEs and managers/nurses working in health care facilities which use agencies, as well as the interviews with employers and nursing leaders and the scoping review, participants were asked about their perception of why health care facilities use agencies. Interviews were also completed with two employers who never used agencies. They were asked about the factors that led to this decision and the challenges they experienced. Lastly, nursing leaders were asked about their perceptions of why the use of agencies has increased so dramatically in the last year. This section will summarize all responses.

Survey completed by CNEs

Using the survey completed by CNEs, 15 participants responded to the question about why they use agencies.

A. **Workforce shortages**
All identified workforce shortages as the main reason as they were unable to fill current vacancies with staff they employ, they required coverage for vacation/sick time, and they had difficulties recruiting into vacant positions. One stated that they currently only use agencies where the vacancy rate is high and expect to stop shortly. The areas of critical care and ED were two areas where staffing was needed the most.

B. **Fulfilling service obligations to community**
Five participants outlined that using agencies was essential to remaining open and fulfilling the service obligations to their communities. A small number noted that they had used agencies for several years to fill positions that could not be filled internally. Others stated that, *"every effort is always made to deliver services with health authority staff and limit the use of agency resources; however, using a variety of staffing options ensures the best care for patients, clients and residents."*

C. **Rural and remote settings**
Participants working in rural/remote facilities identified staffing challenges as being more complex and pronounced noting that they were hit hard with the health human resources crisis. They had other initiatives already in place, such as team nursing and innovative nursing models for a rural hospital, but it still was not enough to retain nurses.

Table 29
Perceived reasons health care facilities use agencies: surveys completed by managers and nurses working in health care facilities which use agencies

	Managers	Nurses
	%	%
Staffing shortage/vacancies	70.1	71.4
Poor retention strategies for permanent nurses	12.4	12.8
To staff vacation time, sick calls, leaves (medical, maternity)	6.2	4.1
More cost-effective and convenient for administration	1	3.2
Difficulty staffing specialty areas	2.1	2.8
Difficulty staffing rural/remote locations	5.2	2.5
Permanent nurses leaving to work for an agency	3.1	1.6
Difficulty staffing specific shifts (e.g., nights)	-	1.4
To provide specific care (e.g., close observation of a patient)	-	0.2

Participants could provide more than one response. Therefore, in each column/group the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Surveys with nurses and managers

In the survey of nurses and managers working in health care facilities which use agencies, participants were asked to identify the main reasons their health care facilities currently use agencies and could provide more than one response. The two most frequent responses in both groups were overall staffing shortages/vacancies and poor retention strategies used by the facility for permanent nurses (Table 29). The lack of retention strategies was not reported in the CNE surveys.

Interviews with employers from facilities where agencies are used

Four CNEs and managers who work in facilities which use agencies were interviewed, including a rural and remote facility, a rural LTC home and two large urban hospitals. One rural setting and one urban hospital had used agencies prior to the pandemic, while the remaining two sites started using agencies during the pandemic in the past 1-2 years. All four participants reported an increase in the number of nurses required from agencies during the past four years, with some facilities doubling their percentage of agency staff at the peak of the pandemic in 2022. One rural setting reported a vacancy rate post pandemic between 35-45% for nurses. One urban hospital reported that nurses had left ICU positions to work for an agency, then returned to the same ICU on contract with an agency.

Factors considered when determining their use of agencies

Participants were asked what factors their facility considered when determining the use of agencies, and identified similar factors discussed previously by CNEs. All participants identified the commitment to delivering services to their communities, keeping their facilities open and avoiding service disruptions. They reported that agencies offered flexible staffing that was needed for service stability overall.

Participants also reported that agencies were needed to provide relief, vacation time and ensure nurses weren't working shorthanded. They discussed how the uncertainty and complexity of working in the pandemic led to many nurses retiring early or leaving the profession due to stressors/workload. One participant stated their facility went from 10% to 18% turnover at the peak of the pandemic in certain practice areas, such as critical care and ED, as nurses experienced rising moral distress due to increased Covid-related patient deaths, and increased stressors including constantly changing information and protocols. Other participants identified growing populations, increased chronic illness, not enough graduates to replace retiring nurses, sick leaves, and leaves for short-term/long-term disability. One participant stated that staff were not adapting the same as they had in the past. All noted that with staffing shortages, it was hard not to use agencies when there was no alternative option to finding additional nurses.

Below are quotes from the four employer participants who use agencies expanding on the factors taken into consideration when using agencies.

> *"So, the fact is that we're using privately run agencies, because that's all that's available. And people are desperate, and they want to serve the communities they are here to serve. It is devastating, especially for the smaller communities, to lose their EDs and what little ICU capacity they have."*

> *"… there was a conversation at the time I recall myself and some of the clinical vice presidents where the agencies were increasing their pricing, and we had to make decisions on whether we would continue to engage with those agencies or not as they increased their prices that they were charging us as an employer."*

> *"… this is a decision you don't take lightly. It's public money. We're always conscientious of how we spend that. And yet, there's a real tension between making sure you have the right people, people who are capable, the people who have the knowledge and skill to do the job and maintain the ability to care for people in need when we have to keep provincial programs open, and we have to – we don't shut the doors of the hospital. So, we did make those decisions to pay more than we were paying previously. We did have a lot of conversations about the ceiling. When was enough, enough? When would we not be paying more? But particularly in the pandemic, then it became if we weren't going to hire agency staff, then the burden was on our staff. And a bit of a catch-22 because if we weren't bringing in agency nurses to support the staffing needs, then the hospital-based nurses were carrying the full caseload and complexities and burdens of the patients that needed caring, and that likely would contribute to the dissatisfaction, the burnout, the turnover, the leaving the organization. So, we really tried to balance the fiscal responsibility with enabling a work environment that allowed nurses to care, as best they could, for patients during the pandemic with the right amount of staff mix and staff ratio and staffing on each shift."*

"So, we made the decision, and actually our nurses were thankful, like we had recommendations, nurses asked in different forums, and the decision was before that we would rather pay our nurses more than bring in – and they were like, "You need to," because they were burning out." "What we wanted, and we were very clear, is that we don't want our staff leaving and coming back the next day as agency. So, we made the decision to contract with one agency. And we were very respectful of our partner organizations that we were, I know this sounds harsh, but we don't want someone leaving the hospital 40 kilometres away to go work agency and come to our emerg. I know that may seem like we're limiting things, but I think that if you think about keeping the system open, our decisions, we didn't want to impact another organization."

Employers working in rural and remote facilities

Similar to the findings from the surveys with CNEs, interview participants working in rural and remote facilities discussed the geographical challenges and difficulties they had hiring new nurses or finding nurses to fill temporary positions. One participant described how they could not compete with the urban facilities as a limited number of nurses want to work in rural or remote settings. Another participant described how they had been actively recruiting for more than five years but were unable to find anyone to hire. Below are quotes from the two employer participants working in rural and remote facilities who use agencies to expand on these factors.

"I think agency staff particularly for smaller rural sites has been a part of our reality for some time. You know initially as offering that kind of flex solution for periods of increased, short-term pressures. And then over time it has become a much more significant reliance. And one of the things that I think is really shifting the landscape is that this is now not just a rural challenge, as we know. And so, as the larger tertiary sites are also relying more increasingly on agency staffing. It is actually drawing away from the rural sites in a way that's creating a whole other set of challenges. Just in terms of the rural sites, including ours, being able to continue to recruit through that means."

"… they saved me because I was working my job Monday to Friday, and then I'd go home, change of clothes, put a uniform on and work the nights all weekend, and then sleep to Monday, and then come back on Tuesday. So, I did that for about a month and a half, and I said to my board, because we have a board. So, I told them, "If you want me to keep this position, we have to do something." So, that's why we ended up going with agencies because my nurses were all either on sick leave, maternity leave, one had left. That's why we hired [a small number of nurses from agencies]. We're not able to replace them."

"… at one point last year we had 15 empty beds that we did not fill because we didn't have the staff to take care of them. And because our wait list is long to come in. So, at one point we had X people on the wait list to come here, but we could not admit them because we had no staff, so they were either at the hospital, at home with services. But they were not at the right place for the care that they need, but we couldn't provide the people to take care of them."

"So, it's just a very fraught time in health care. I don't know why I'm so emotional about it. It's hard to be seeing my team left to function beyond the end of their rope. And so, when you step

back and you look at it, it's a tough thing to not be reliant on something like agency, we recognize the challenges and trade-offs and yet we'll gobble those contracts up so fast because we just want our team to be stable."

Interviews with nursing leaders in Canada

Nurse leaders in Canada were asked about why they think, or what they have heard, about the reasons health care facilities are using agencies. Their responses focused on the nursing shortage and nurses leaving the public system due to a lack of respect, wage oppression such as Bill 124 in Ontario, lack of retention strategies to retain nurses in the public system, and burnout of the mid- to late-career nurses. They also discussed the changing demographics in nursing with the aging workforce and younger generations wanting to work in a different way, especially with scheduling. One point the nurse leaders raised, which was not raised previously, is that government has refused to listen to frontline nurses and instead has focused on other initiatives such as recruitment strategies or offshore recruitment from other countries. Below are quotes from the nurse leader participants to expand on these factors.

"In order to not have to close institutions, decrease services, or particular services in particular institutions… emergency departments have been a big one, but inpatient units have, and long-term care have been huge… So, it's almost like we weren't talking about the nursing shortage, and then all of a sudden it was like, "What happened?" And I think we're all in that headspace where we're like, "What happened? Was it COVID? Did COVID really do that number on us? But when we look back at the numbers, we were already creeping up with the vacancies. Not something that we hadn't predicted. We have an aging workforce."

"Public health care facilities are using agency nurses because they've got so many empty positions, we are almost 1000 full time equivalent short of registered nurses in this province, and they are doing virtually nothing to retain the people that are here. The mid to late career nurses they've abandoned, they're hanging their hat completely in this province on recruitment from offshore, and you're not going to put a brand new Canadian into the intensive care unit or emergency room. So that's why, that's exactly why."

"… nurses are tired of being treated like a commodity, that we are professionals, that we practice nursing just like our colleagues in medicine practice medicine. We are not subordinate, we are a member of the team, we are leaders in the sector, and the wages and scheduling are creating an environment where we are not valued and not respected for what we bring to the table."

Scoping review

The reasons reported by survey and interview participants were consistent with those found in the scoping review which also identified the nursing shortage (Bae et al., 2010; Benson, 2012; Brazier et al., 2023; Castle, 2009; Cicellin et al., 2015), and the need to fill nursing vacancies in LTC homes (Alvarez et al., 2011), hospice/palliative care units (Cozad et al., 2016) and hospitals (Benson, 2012; Manias et al., 2003b; Newhouse et al., 2005). One other

reason identified by survey participants that was also reported in the literature was the need for specialized nurses in areas such as critical care (Peerson et al., 2002; Rispel et al., 2015).

However, there were two additional reasons identified in the literature. First, the need to meet patient/staff ratio regulations, as reported in two studies in LTC homes in the United States (Brazier et al., 2023), critical care units in South Africa (Matlakala et al., 2016), and an international systematic review (Mazurenko et al., 2015). Next, the literature identified how hospitals hired "preferred agencies" temporarily instead of hiring permanent staff as a cost saving measure without impacting service delivery (Pham et al., 2010; Rispel et al., 2015).

Health care facilities who do not use agencies

Two interviews were also conducted with CNEs working in urban hospitals which have never used agencies. At one facility, two participants joined (CNE and human resources) and their responses are reported as one participant.

Factors considered in facility's decision to not use agencies

Participants identified that some factors for their decision to not use agencies were based on discussions with other facilities who had identified the challenges of working with agencies. These factors included: 1) the negative impact on staff morale when working alongside nurses who were making significantly more money in the same role; 2) learning that they did not always receive the skillset they requested and paid for when working with agencies, and 3) determining that it would be hard to 'come back' from using agencies. Other factors included: 1) having a strong belief in the public system, and 2) the financial impact on the facility if money was spent on agencies versus paying nurses in their facility overtime. Instead, the participants and facilities focused on building their own 'pipeline' of nurses to fill their staffing needs, maximizing the scopes of practice of nurses, and spending money on the nurses working in their facility rather than on agency costs. Below are quotes from the two employer participants who do not use agencies to expand on these factors.

> *"There were conversations with our professional practice team because we knew that there were some of the rural partners, as well as one of the other tertiary care centres in our area that were having to use agency staff. And we talked about what that was, what that would mean psychologically for a very tight-knit team. And there were a lot of concerns about – especially with Bill 124 – that it would be degrading for the nurse to work alongside somebody who was being paid more. And that would be further disenfranchising people – you know, like that would be very tough to see." "So, we didn't say that we weren't going to be looking at agency, but we wanted to ensure that we had exhausted everything in our existing team and supports."*

> *"It was largely driven by our collective belief that it is incredibly demoralizing and bad for the team to have nurses providing care, making ridiculous amounts of money, standing next to a nurse who's making the contracted wage."*

> *"And then I think one of the other really interesting aspects was once you started going down that path with the agency nurse, what I was hearing was it was very challenging to step back from that. Because it was a really great band-aid for in that moment but what you really had to concentrate*

on was the pipeline. How you rebuild the pipeline and how you ensure that you're retaining your staff. And I think that for a lot of – some staff who used agency, that retention factor started becoming an issue in the early days where some of their staff would start leaving because they knew they could make more money."

Challenges in not using agencies

Both participants stated that it was very challenging not to use agencies. There was a high amount of sick time due to high levels of stress and overtime related to practice areas working short-staffed. There was added stress on managers and leadership as they came in on weekends in the short-term to support frontline nurses until extra resources were put in place.

They reported financial challenges with the high cost of overtime, increased costs to onboard new staff and needing to increase the education budget to support professional development. The biggest challenges were in the highly skilled areas (e.g., ED) due to the advanced skill set and finding ways to optimize the nursing role while having support for the non-nursing activities. Models of care were changed, when possible, by adding LPNs to critical care areas and Eds to optimize their roles. An additional challenge was determining when nurses in their facilities were asking for a leave of absence so they could work for an agency in the north or on the coasts, which in turn was adding to the facility's staffing shortage. Below are quotes from the two employer participants who do not use agencies to expand on these challenges.

"I think overall for the rest of the hospital it was – I think our strategy worked really great. Where we had more of a challenge was in our emergency department because you have a very highly skilled staff." "The emerg was a little bit of a tougher situation because they were very used to having well-seasoned nurses and bringing that in. When I spoke to other hospitals who were having the same emerg problem, the agency nurses mitigated it but not to the extent that they thought it would."

"I also think that we were also cognizant of the monetary impact. And I would be – I think we all need to also understand that there is an impact on your budget." "From a senior leadership team, we also had to look at OK, so what was the cost of an agency staff, what is the impact from that point of view versus if we were paying overtime and those aspects."

Why has the use of agencies increased so dramatically in the last year?

Based on their opinions and experiences, nurse leaders were asked why the use of agencies has increased so dramatically in the last year. While this question was posed to the nurse leaders, two employers also provided thoughtful reflections about this during their interviews and are included in the quotes below. Areas that were identified included underlying contributing factors, underestimation of nurses leaving, demographic shift in human resources, challenges of pulling back from reliance of agencies, and entrepreneurial dreams.

Underlying contributing factors

"I think that it's an interesting exploration around why we, in health care in general, why we got to this place where we are so dependent on agencies, and I think we need to really pay attention to the underlying root contributing factors to that. And it's beyond the pandemic. The pandemic definitely exacerbated the challenges, but several of these challenges were in the mix before the pandemic, and collectively as a health system, we have not been paying attention really to the needs of nurses and the need to create healthy and safe workspaces." (Employer participant who uses agencies)

"… we are seeing a lot of registered nurses just saying, "I'm done, and the pension and the benefits don't mean anything because my mental health is not going to survive another day in this system." So, we really [need] to start meeting people where they are. What that means, or what that will look like, I don't know. But I think we have to start with changing our way of thinking about the nursing workforce too." (Nurse leader participant)

"… they've told me that they can't get time off, they don't feel valued, they don't feel appreciated, they don't feel their work is recognized. They are constantly bombarded to work overtime. It's endless. And they're tired, they're burnt out. The workloads are outrageously high. They feel that they're working in environments that are no longer safe, but it seems to become normalized, and people think that that's OK." "I've gone to a number of meetings and tried as much as I can to get in front of nurses and groups of nurses and some of the stories, I've heard are just heart wrenching. I remember a nurse getting up and talking about their experience and actually they said, "I have contemplated on my way to work in the morning getting into a head-on collision knowing that that's the only way I can get a day off." (Nurse leader participant)

"So, that's the other pressure that I don't think a lot of people understand is because there was such a need for staffing, nurses get, they get tired when they're called on their day off. Well, can you please come in? Can you come in and help us? Could you just change your schedule to be here today because we're really short-staffed? And that's really wearing. So, all those things I think contributed." (Employer participant who uses agencies)

Underestimation of nurses leaving

"I would say that our vacancy rates are so high that organizations have had to scramble to do all kinds of things in order to try and maintain services for the public." "And my feeling is it's because nursing is a massive workforce, they're women largely and so we didn't have to do anything for them. They're not going to go anywhere anyway. A lot of employers thought the nurses would never follow through with their threats to walk and they have. And so, I think in some ways nurses have been maybe underestimated at their willingness to be unemployed over working in an environment that's toxic and unpalatable. And that's exactly what's happened." (Nurse leader participant)

"… from my perspective, nurses aren't prepared to just accept things anymore. That broken equipment is acceptable or we will make do with this. You know, we've always fix things: a good tape job would fix anything. That's what we said, to get the waterproof tape and we're good to go. Nurses aren't willing to accept that anymore. They're not willing to accept it, for their patients.

They're not willing to accept it for themselves or their profession. And so I think that leads to agency again, that nurses want to have control of their workplace of their environment, of their scheduling, of their wages, and gone are the days of martyrdom." (Nurse leader participant)

Demographic shift in human resources

"I think that we've had a demographic shift in human resources that's been predicted for several decades. I think this has been known or conceptualized anyway, for some time. But we have the confluence of added pressures with Covid, and so on. We saw more experienced people, in later stages of their career leave in droves. And we have added pressures of growing populations, and populations that are aging and with chronic conditions. It is more complex, the scene out there in terms of health needs. So, it adds pressure onto the system. And then we have a younger workforce that's coming up with really different expectations and prioritization between how they define work-life balance and how they're willing to work. And I think that there's been a lot of holding up a system that is aged out, so to speak, in terms of its ability to keep up with all these different layers of complexity." (Employer participant who uses agencies)

Challenges of pulling back from reliance on agencies

"… it is adding a lot of pressure onto a health system that's fragile and people, that's the lived reality of staff. People that are still working in direct patient care and there's no easy fixes. And so when you have kind of a flexible layer like agency staffing offers, a system that's already taxed is really gonna like gobble that up. Lean into that weekly. Whereas I think in a healthy environment, you're always going to need to have some degree of flex factor like that. But instead of it being like a compliment, it's become a really heavy reliance in a way that's eroding the original intent. I would say overall. But it's hard to pull back from that usage or reliance without an alternative. And I think to design that alternative really takes – you have to kind of take all of that into consideration. And its way upstream in terms of recruiting new generations into right at the source like how you're training at people, how you're lowering those barriers." (Employer participant who uses agencies)

Entrepreneurial dream

"… there was a real awareness for me anyway that this was a bit of an entrepreneurial dream. So, agencies are run by individuals who benefit by running this business and making a profit. And there was a reaction to that. And I got several emails and letters and people reaching out saying, "I'm starting an agency. Would you hire me? Would you hire nurses from me? Can we get a contract?" So, there was also a very interesting, just a market force that was happening at this time. So, agencies, they knew they could increase their prices and hospitals would purchase the services because we needed them. And then there were other individuals who were entrepreneurial in nature, and they were creating new agencies or extending their agency because they knew the health care system needed staff." (Employer participant who uses agencies)

11. What are the experiences of managers and nurses working in health care facilities using agencies?

In the surveys with nurses and managers who work in health care facilities which use agencies, participants were asked questions about their experiences, which factors contributed to their staying in the public system and what strategies and initiatives would influence other nurses to stay in the public system. This section will summarize those responses.

Work status and types of facilities where managers and nurses worked

The majority of the manager participants reported their work status as permanent full-time (82.6%), and the most common health care facilities where they worked were hospitals (42.4%) and LTC homes (34.8%), with the most frequent responses for common specialty areas being LTC (32.4%) and the ED (7.6%). The majority of nurse participants reported their work status as permanent full-time (56.2%) and permanent part-time (30.9%). The most common health care facilities where they worked were hospitals (72.6%) and LTC (14.2%) with the most frequent responses for common specialty areas being ED (17.2%), geriatrics (14.0%) and critical care (11.3%).

Numbers of nurses from agencies per shift

In general, the manager participants reported there was an average of five nurses (M=4.9, SD=15.2) from agencies working each shift in their facility or unit, with a wide range of 0 to 100 reported. Those who reported 0 indicated that their facility used agencies more in the past than currently or because of their specialty area they did not use agencies, but they were used elsewhere in the facility. Most manager participants reported working with nurses from agencies on a daily basis (52.5%) or 1-2 times per week (19.6%), with an average of 50 minutes (M=50.0, SD=15.2) spent each shift training, directing or redirecting them. Again, there was a wide range of 0 to 240 minutes (4 hours) in the amount of time spent.

Nurse participants reported that, in general, there was an average of 3-4 nurses (M=3.4, SD=8.2) from agencies working each shift in their facility or unit, with a wide range of 0 to 100 reported. Those who reported 0 indicated that their facility or unit used agencies more in the past than currently or because of their specialty area they did not use agencies, but they were used elsewhere in the facility. Most nurses reported working with nurses from agencies on a daily basis (51.5%), 1-2 times per week (20.7%), or once a month (6.8%) with an average of 73 minutes (M=72.8, SD=115.4) spent each shift training, directing or redirecting them. Again, there was a wide range of 0 to 720 minutes (12-hour shift) in the amount of time spent.

Factors contributing to their staying in the public system

When asked what factors contributed to their staying in the public system, manager participants identified benefits (health and pension) (29%), importance of community and morals/values when deciding between the public and private health care systems (12.2%), importance of keeping seniority (10.7%), and valuing consistent teamwork with job satisfaction (9.9%). Nurse participants identified benefits (health and pension) (34.6%), but also identified wanting to stay within a union (20.2%), importance of keeping seniority (19.9%), and wanting stability/familiar environment due to family obligations (15.6%) as factors contributing to their staying the public system. Just over five percent also identified the importance of community and morals/values when deciding between the public and private health care systems. Some differences between groups may be based on age as the average age of managers was close to 50 while the average age of nurses was closer to 42 years. Table 30 outlines the remaining reasons identified by both groups.

Table 30

Factors contributing to staying in public system: surveys completed by managers and nurses working in health care facilities which use agencies

	Managers	Nurses
	%	%
Benefits: health and pension	29	34.6
Union	7.6	20.2
Seniority	10.7	19.9
Stability, family obligations, familiar environment	6.1	15.6
Community, morals/values, ethical dilemma: public vs. private	12.2	5.4
Teamwork/job satisfaction	9.9	5
Job security and guaranteed hours	4.6	5
Wage, bonuses and differentials	2.3	4.1
Work-life balance and schedules	3.1	3.1
Age/close to retirement/retired	3.8	2
Vacation	2.3	1.7
Safety, quality of care and workloads	3.1	1.3
Professional growth/gain experience in specific area	4.6	1.2
Respect (negative and positive)	–	0.6
Management (negative and positive)	0.8	0.2
Other	–	0.1

Participants could provide more than one response. Therefore, in each column/group the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Strategies and initiatives to influence nurses to stay in public system

Participants were asked to identify what strategies/initiatives would influence nurses to stay in the public system. As the responses from nurse and manager participants were similar, they were combined to provide an overview of their overall responses. Participants could provide more than one response. The two most frequent responses were increased wages and equity including new or increased premiums (31.2%) and improved working conditions (better workloads, nurse-to-patient ratios, no more mandated overtime, decrease levels of violence) (14.5%). Close to 10% of the responses also identified scheduling flexibility and work-life balance, while close to 7% identified improved benefits such as pension and health benefits as well as mileage, shoe and uniform allowance and 6% identified respect/appreciation and recognition for expertise. See Table 31 for additional responses.

Table 31

Strategies and initiatives to influence nurses to stay in public system: combined surveys completed by managers and nurses working in health care facilities which use agencies

	%
Wage (increase and equity), premiums (new and increase)	31.2
Work conditions: workloads, nurse-to-patient ratios, no overtime mandates, violence	14.5
Schedule flexibility, work-life balance	9.6
Benefits: mileage, pension, health, shoe and uniform allowance	6.6
Respect/appreciation, recognition for expertise	6.2
Incentives/bonuses: retention, long-service, sign-on	5.3
Approve vacation/time off, increase sick/personal/mental health days	4.8
Leadership (management, directors and government) support	3.5
Career advancement, education opportunities, funding/reimbursement	2.4
Positive work culture/improved morale	2.3
Other	2.3
Retention focus and programs	1.8
Flexible roles, opportunities and work status	1.7
Support for bedside care (more support staff, equipment, unit structure)	1.7
Frontline feedback heard/understanding reality of nursing work with actual action	1.3
Regulate private agencies with transparency	1.3
Better union support, bargaining and contracts	0.9
Housing and cost of living adjustments	0.8
Childcare and gender equity	0.7
Transition support: new grad, mentorship (keep senior nurses), orientation	0.6
Improve the health care system (e.g., funding, patient flow)	0.5

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

12. What are the advantages and disadvantages of health care facilities using agencies?

In the survey of nurses and managers working in health care facilities which use agencies, as well as the interviews with employers and nurse leaders, participants were asked to identify the advantages and disadvantages of health care facilities using agencies. This section will summarize those responses with the exception of the nurse leaders' identification of disadvantages as their responses focused more on the implications of using agencies and their responses are summarized in the next section.

Advantages

Advantages identified in surveys

As the responses from nurse and manager participants were similar, they were combined to provide an overview of their overall responses (Table 32). The two most frequent responses for advantages were the additional nursing staff helped to fill vacancies, improved the nurse-to-patient ratio and decreased workload (58%), and nurses working with agencies were knowledgeable and shared experiences (21.8%). Additional responses included: nurses from agencies were willing to pick-up last minute vacancies/shifts and were adaptable (7.7%), the use of agencies helped to decrease mandates for overtime and redeployment to other areas (3.5%), the use of agencies provided the ability for permanent nurses to take vacation and have time off (3.0%), the extra staffing improved permanent nurses mental health (2.3%), the use of agencies prevented closures or cancellation of services (1.9%) and nurses working with agencies didn't become involved with unit politics (1.6%).

Table 32

Advantages of facility using agencies: combined surveys completed by managers and nurses working in health care facilities which use agencies

	%
Fill vacancies, improve nurse-to-patient ratio, decrease workload	58.2
Nurses from agencies were knowledgeable, shared experiences	21.8
Willing to pick up last-minute vacancies, adaptable	7.7
Decrease in mandating, decrease reassignment/redeployment	3.5
Able to take vacation and time off	3
Improve staff mental health – decrease stress and burnout	2.3
Avoid closures/cancellation of service	1.9
Not involved in unit politics	1.6

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Advantages identified in interviews with employers from facilities where agencies are used and nursing leaders

Interview participants discussed how the use of agencies was key to keeping services open and maintaining service continuity. In addition, agencies also ensured nurses had vacation time, time off and adequate staffing, which helped with staff wellness and ensured the delivery of safe care. Some participants also described how nurses from agencies who were experienced nurses helped with 'cross-pollination of ideas' as they brought new perspectives and experience levels having worked in other facilities. Several participants also discussed how permanent nurses did not like being reassigned to other units due to staffing shortages, and using agencies helped to fill that gap.

Keeps services open and maintains service continuity, especially in rural and remote areas

"… the only advantage that I see is that it can help ensure a continuation of service in a small community that is very restricted or limited on the service they get anyway. And that you need to utilize a staffing mechanism like that in order to be able to recruit. And I'm talking outposts, I'm talking far north where there's nothing there, you're not going to recruit someone with a family to go live there. It's those sorts of places that I think that there's value to have travel nurses. That said, I think we'd be better if the province or territory that those communities lived in, own their own travel nurse company and operated it within the system and not as a private for-profit entity." (Nurse leader participant)

"And when we have the vacancy rate we have, we need to fill those gaps. Because it just exponentially contributes to the burnout of the remaining staff when we're constantly running short. So yes, it stabilizes our service. It allows us to keep our doors open to the community, in a community in a snowstorm, or a fog comes in, there's nowhere else to go. Even having a fully staffed busy ambulance crew, we can't always move patients… We are the service, and it has to be open." (Employer participant who uses agencies)

Provides permanent nurses with vacation and time off

"… the advantage when they first introduced them here in every sector was that there are nurses who had not gotten any vacation for two years. So, it provided them the opportunity to be able to avail some time off. It also helped that we didn't have to shut down services in particular facilities or even close facilities, particularly long-term care, which was, that was the biggest need that we had in the beginning, of course, and the rural and remote areas." (Nurse leader participant)

Provides flexibility and opportunity to learn about other environments

"… I think the variety is something that nurses seem to want. They like the flexibility, that they're not always called, and they can really pick and choose when they want to work." (Nurse leader participant)

"…often we do get experienced and skilled staff who, if they're returning to us frequently, they do know our environment. They generally work with one team or in one area. So, they do become a part of the care delivery team. I think that's, again, variable depending on the individual. So, the upside is they can be very helpful in us delivering our service." (Employer participant who uses agencies)

"I think agency staff can bring all kinds of expertise, all kinds of specialized training based on the variety of their practice experience, because they have bounced around perhaps, or they have had a variety of practice contexts." "And so that's actually super helpful to inform care delivery, to influence colleagues." (Nurse leader participant)

Reduced reassignment or redeployment to other practice areas

"We have a lot of work, all of us, to recruit and retain, but it helped us stabilize our workforce. We had a lot of huge reassignment trends, because if you think about risk management enterprise wide and… you've got X number of nurses. Where's the best place to put your nurses? You may have really good staffing on one unit and another unit is very short." "… our reassignment trends for our nurses were – and it was a huge, it is a huge dissatisfier for nurses. So that helped with that. Our reassignment trends now are the lowest they've ever been." (Employer participant who uses agencies)

Disadvantages

Disadvantages identified in surveys

The responses from nurses and managers were combined to provide an overview (Table 33). Close to 23% of participants' responses discussed the sense of the loss of unit values and culture as they were continuously working with a new team member who didn't understand 'who we are and how we work'. This was followed by the loss of a 'consistent team' where they were no longer working with familiar faces, people they knew and trusted, resulting in little camaraderie at work (18.1%). Eighteen percent of the responses identified the never-ending training, directing and answering questions that they needed to provide, followed by the frustration with no, little or inadequate orientation being provided by the facility to nurses working with agencies (12.3%). Ten percent of responses discussed concerns about patient care (quality, safety, continuity, planning and advocacy) with the constant turnover of team members. The significant pay disparity (8.5%) affected participants' morale as well as impact on work schedules/hours (5.5%). Participants' responses also discussed how they were expected to float or be deployed to other units, were no longer offered overtime, part-time and casual staff lacked the same number of shift opportunities, with management holding shifts for agencies or booking agencies before offering the same shifts to the permanent nurses. Close to three percent of the responses identified how the costs of agencies were draining the facility's budget which in turn reduced the resources available to the permanent nurses, such as educational opportunities. Just over one percent of the responses reported that there were no disadvantages, while just under one percent reported that the current situation was not sustainable for the facility or nurses.

Table 33

Disadvantages of facility using agencies: combined surveys completed by managers and nurses working in facilities which use agencies

	%
Sense of the loss of values and culture as a unit – 'who we are and how we work'	22.6
Loss of 'consistent team' – familiar faces, camaraderie, knowing who you work with	18.1
Never ending training and directing	18
Inadequate orientation provided	12.3
Negatively affected patient care	10
Pay disparity	8.5
Impact on work schedule and hours	5.5
Budget drain, impacts funding/resources for permanent nurses	2.9
No disadvantages	1.4
Not a sustainable solution	0.6

Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Table 34
Impact of working with an agency on teamwork: surveys completed by nurses working with agencies (past and present)

	%
Has working with an agency impacted your nursing practice in working effectively within the nursing team?	
Yes	64.3
No	35.7
If yes, please describe how.*	
Improved skills in being a team player	28.9
Increased adaptability/flexibility to new clinical areas and teams	22.1
More experience working with people on different teams, personalities, styles and cultures; better "people skills"	20.1
Negative experiences with lack of support, feeling alone, being an outsider	12.1
Increased and improved communication with others; increased confidence to advocate	10.7
More exposure to different ways of practicing in health care	6
Has working with an agency impacted your nursing practice in working effectively with other providers (outside nursing team)?	
Yes	57.3
No	42.7
If yes, please describe how.*	
Increased adaptability/flexibility; exposure to different health care roles and personalities	55.4
Improved communication skills	24.1
Less assertive working in new place; treated differently; lack of familiarity; difficult teamwork/communication; had to earn trust of team and demonstrate competence	20.5

*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

13. What are the implications of using agencies in Canada?

In the surveys and interviews with nurses working with agencies, nurses and managers working in health care facilities which use agencies as well as the interviews with employers from facilities where agencies are used and nurse leaders, participants were asked questions about the implications of using agencies. This section will summarize all responses.

Surveys with nurses working with agencies

In the survey with nurses working with agencies, participants were asked how their experiences during their work with an agency had impacted their nursing practice in the areas of teamwork, feeling comfortable on a unit/area, providing safe patient/client/resident care, and providing care to the same patients/clients/residents over time.

1. **Teamwork**

   When asked if working for an agency had impacted their nursing practice in working effectively within a nursing team, just over 64% reported that it had an impact (Table 34). When asked to describe how, participants could provide more than one response. The majority of responses reported a positive impact with improved skills in being a team player (28.9%), increased adaptability and flexibility working in new practice areas and teams (22.1%), more experience working with people on different teams and developing better 'people skills' (20.1%), increased and improved communication with others (10.7%), and more exposure to different ways of practicing in health care (6.0%). However, just over 12% of the responses reported a negative experience with a lack of support in facilities, feeling alone and being an outsider on the nursing team.

   Next, participants were asked about the impact on working effectively with other providers (outside of the nursing team) (Table 34). Just over 57% reported that it had an impact, and similar to working within a nursing team, participants could provide more than one response to describe how. The majority of responses reported a positive impact. This included increased adaptability/flexibility to new team members with exposure to different health care roles (55.4%), and improved communication skills (24.1%). However, 20.5% of the responses also reported a negative impact as participants felt less assertive working in new places with difficult teamwork/communication due to the lack of familiarity, being treated differently and having to earn the team's trust by demonstrating their competence.

2. **Feeling comfortable in a unit/area**

   When asked how well they integrated into the culture of various units, 74% of participants reported they generally integrated extremely or very easily into the culture of various units, while 9% reported it was extremely or very difficult, and 17% were unsure. When asked if working for an agency had impacted their nursing practice in feeling comfortable in a unit/area, close to 67% reported that it had an impact (Table 35). When asked to describe how, participants could provide more than one response. The responses

describing the positive impacts included learning to quickly adapt and be flexible in a new unit/area (28%) and experiencing professional growth and development with increased confidence and independence (26.4%). Participants' responses also identified factors that helped them feel comfortable including having time to become familiar with an area and returning to the same area (12%), having a supportive environment with orientation, supportive staff and support from the agency (8%), and having previous experience (3.2%). However, responses also identified a negative impact as participants were uncomfortable and unfamiliar in a new area or unit, or the environment felt unsupportive (16%) and they felt pressure in a new unit or area due to the wage discrepancy or perception of agencies (6.4%).

Table 35
Impact of working with an agency on feeling comfortable in a unit/area: surveys completed by nurses working with agencies (past and present)

	%
Has working with an agency impacted your nursing practice in feeling comfortable in a unit/area?	
Yes	66.6
No	33.4
If yes, please describe how.*	
Quick adaptability and flexibility	28
Professional growth and development; increased confidence and independence	26.4
Uncomfortable, unfamiliar with unit and unsupportive environment	16
Time required to be familiar with area, return to same area	12
Supportive environment: supportive staff, orientation, agency support	8
Felt pressure due to increased wage and perception	6.4
Previous experience/level of experience helpful	3.2

*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

3. Providing safe patient care

When asked if working for an agency had impacted their nursing practice in providing safe patient care, close to 57% reported that it had an impact (Table 36). When asked to describe how, participants could provide more than one response. The responses describing the positive impacts included increasing their knowledge, skill and judgement due to variations in practices (25.6%), increasing their focus on following policies, standards, best practices and understanding their scope of practice (14.7%), and enhancing their communication skills (8.8%). The responses also identified supportive factors which helped enhanced patient safety, including working on smaller teams, having proper nurse-patient ratios and working in the same facility (20.6%). Based on the responses, working with an agency in different areas also increased participants' awareness of unsafe practice areas due to a lack of staff and supplies (11.8%), and the potential for unsafe practice due their lack of knowledge about a unit's routines and policies as well as being given unsafe assignments (7.8%). Seven percent of the responses reported improved cultural competency due to their experiences, but also identified the challenges that may occur with language barriers. And 4% of responses reported that participants 'tried to stay afloat' when working in different units or areas.

Table 36
Impact of working with an agency on providing safe patient care: surveys completed by nurses working with agencies (past and present)

	%
Has working with an agency impacted your nursing practice in providing safe patient care?	
Yes	57.1
No	42.9
If yes, please describe how.*	
Increased knowledge, skill and judgement due to variations in practice across areas	25.6
Supportive factors: smaller teams, nurse-patient ratios, working in same facility	20.6
Increased focus on following policies, scope of practice, standards, best practices	14.7
Aware of existing unsafe environments due to lack of staff, supplies	11.8
Enhanced communication/teamwork with team members, staff, agency nurses	8.8
Increased potential for unsafe practice due to lack of knowledge of unit, not knowing routines, unit policies, possible unsafe assignments	7.8
Language barrier a challenge at times, improved cultural care	6.9
Tried to stay afloat	3.9

*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Table 37
Impact of working with an agency on continuity of care: surveys completed by nurses working with agencies (past and present)

	%
Has working with an agency impacted your nursing practice in providing care to the same patients over time?	
Yes	47.1
No	52.9
If yes, please describe how.*	
Not a concern if consistent practice environments: same facility, longer periods	36.1
Challenging if inconsistent facilities, inconsistent assignments	31.1
Not a concern if assigned consistent patient assignments	16.4
Challenging in settings (ED, PACU, labour/delivery) with frequent changes in patients	13.1
Gives you a break and allows you to regroup, gives staff a break	3.3

*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

4. Continuity of care

When asked if working for an agency had impacted their nursing practice in providing care to the same patients/clients/residents over time, close to 53% reported that it had no impact (Table 37). When asked to describe how, participants could provide more than one response. Of the 47% of participants who reported that working for an agency had an impact, the majority of their responses identified that it wasn't a concern if they were placed in the same facility/unit and were there for a longer period of time (36.1%), or if they were assigned consistent patient/client assignments (16.4%). Participants' responses also identified that it was challenging if they were in inconsistent facilities or had inconsistent assignments (31.1%) or in practice settings that had frequent changes in patients/clients/residents, such as EDs, labour and delivery units and post-anaesthesia care units (PACUs) (16.4%). A small number of responses also reported that changes in assignments could be positive as it provides a break for nurses (3.3%).

Interviews with nurses working with agencies

In the interviews with nurses working with agencies, participants were asked to discuss further if working with an agency had any impact on them personally or professionally as well as when providing safe patient care of care or ensuring continuity of care with patients/clients/residents.

1. Personally

Participants discussed how working with an agency was positive for them personally with higher wages and work-life balance, however they noted that it could also affect their relationships with colleagues and friends. Below are quotes from the participants to expand on this.

> *"It was just kind of the system and the fact that we were there making quite a bit more money than they were making for the same job. So, some people were upset about that but for the most part, they were happy to have us because they needed the help." "Some staff nurses would share this dislike for the system of agency nursing, but not nurse specific."*

> *"I think that there's been a little bit of – a little bit of an attitude from some nurses with me coming back. Like definitely money was a large portion of why I chose to do that work and some of my co-workers here maybe don't understand that or don't agree with that because we were struggling here."*

2. Professionally

Participants discussed how working with an agency was also positive for them professionally with flexibility, travelling to different areas, opportunities to 'push or test own limits', however one participant identified that the role may not be appropriate for new graduates. Below are quotes from the participants to expand on this.

> *"… professional [impacts] I mean we already talked about the fact that I'm very flexible now which is definitely great. I think that would be the biggest professional advantage is just that I – I've learned to work in different areas. And l like being able to just very easily and*

quickly connect with co-workers… Just being able to connect so that we feel like a team even though we've only worked together for a few hours…"

"Professionally it's definitely given me more opportunity to, I'll say, push or test my own limits in terms of working in under-resourced or under-supported units and kind of seeing how much one person can really do in certain situations. I know not everyone wants to test their limits but that's actually strangely been a draw for me to kind of see when push comes to shove how much can you actually do. Especially when out of – without resources, because I've noticed that with bigger centres too."

"I've told new grads this: that not to go and do travel nursing agency. And the main reason is that you need to have such a strong base on what your scope of practice is, what you can do, what you cannot do. Especially as an LPN. Because people will ask you to perform the role of an RN and to do things and if you are not experienced enough to know this is the line, you can put yourself, your patients and your license at risk."

3. Quality of care

Participants discussed how working with an agency had a positive impact on patient care as units had more staff to provide quality care, and by having more time off participants felt they went to work feeling 'fresh'. One participant outlined how nurses working with agencies may not always be placed in the best areas due to a lack of experience or language barriers. Below are quotes from the participants to expand on this.

"Everywhere has been short-staffed, so just having bodies is a big thing… And I know that the hospitals I was working at, they had over 60 or 70 agency nurses at one time. So, we were filling a large gap. And I think that that definitely positively impacted patient care."

"I don't think there's any difference in quality of care. But especially the last year or so, it has felt like coming back fresh and having that time off has actually improved the quality of care I give. I'm more patient. I'm more understanding of when things go wrong and stuff like that."

"… I know that there were nurses placed in the wrong areas. So, people going to the emergency room who probably should not have gone there. Or agency nurses being placed in French-speaking hospitals who are mostly English-speaking. On the surface it seems like oh, well, you can get by. But there were definitely some issues with that, especially when you're trying to read orders in French and you don't speak French."

4. Continuity of care

One participant discussed how facilities tried to promote continuity of care by keeping nurses working with agencies in the same area, but also identified how the short-term contracts and constant turnover of team members could negatively affect the care being provided over time. Below is a quote from a participant to expand on this.

"I would say the agency and the hospitals, they did try as much as possible to keep you in the same area to promote some continuity of care. And keeping you mostly with the same team as well so that you were familiar with your co-workers. It didn't always happen of course, but they tried to at least. Obviously with me being only there for like a month, that's

not really continuity of care. Like you're constantly having different people join the team and leave the team and it would be tough I imagine."

Surveys with nurses and managers

In the survey with nurses and managers working in health care facilities which use agencies, participants were asked if the use of agencies in their facility had impacted their team's culture and cohesion or the morale of permanent nursing staff as well as patient safety and continuity of care on their unit/area. Due to similarities between the nurses' and managers' responses, the results for the two groups were combined.

1. Team's culture and cohesion

When asked if the use of agencies in their facility impacted their unit's team culture and cohesion, just over 65% of participants reported that agency use had an impact (Table 38). When asked to describe how, participants could provide more than one response. Close to 6% of the responses reported the extra staff helped improve burnout among permanent staff and improved cohesion with new team members while just over 2% of the responses identified that it varied depending on the team members. In contrast, 58% of the responses reported that the constant turnover of team members affected the team dynamics and workplace culture and also increased the workload for permanent nurses as they were expected to provide orientation for new team members, review protocols and ensure they were being followed, and complete additional tasks required for the overall unit function (17.3%). In the responses, participants also reported feeling disrespected by their facility due to the wage disparity, lack of recognition for staying in their jobs, and having their shifts or hours altered to adapt to the new team members (16.7%).

Table 38
Impact of agency use on unit culture and cohesion: surveys completed by managers and nurses working in health care facilities which use agencies

	%
Has the use of agencies impacted your unit's team culture and cohesion?	
Yes	65.1
No	34.9
If yes, please describe how.*	
Constant turnover affects team dynamics and workplace culture	58
Extra workload for permanent nurses: orientation, protocols, overall unit functioning	17.3
Permanent nurses feel disrespected by wage disparity, lack of recognition, shifts/hours altered	16.7
Positive impact: helped with burnout, increased cohesion	5.8
Varies depending on the team	2.2

*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

2. **Morale of permanent nursing staff**
   When asked if the use of agencies in their facility impacted the morale of the permanent nursing staff on their unit or area, over 80% of participants reported that agency use had an impact (Table 39). When asked to describe how, participants could provide more than one response. Close to eight percent of the responses reported improved morale as more staff helped reduce the amount of overtime and mandates while providing opportunity for vacation or time off. In contrast, close to 54% of the responses reported that permanent nurses felt devalued, demoralized and exhausted, 35% of the responses reported a lack of a 'team' or team building when working frequently with new staff, and close to 4% of the responses reported that permanent nurses wanted to or have already quit.

3. **Patient safety**
   When asked if the use of agencies impacted patient safety on their unit/area, just over 69% of participants reported that agency use had an impact (Table 40). When asked to describe how, participants could provide more than one response. Just over 12% of the responses reported that the additional staff helped to improve patient safety on their unit. In contrast, over 40% of the responses reported concerns about patient safety due to the new team members lack of familiarity with patients/clients/residents, policies, unit routines and protocols, charting requirements or scope of practice in facility. Over 27% of the responses reported concerns about the new team members having enough experience in that clinical area or having adequate orientation. And close to 20% of the responses reported challenges related to short-term contracts and limited time on units, including LTC residents not being familiar with nurses leading to increased confusion and aggression, not being able to anticipate long-term patient issues, and not being available for follow-up if there were questions after the shift ended.

4. **Continuity of care**
   When asked if the use of agencies impacted the continuity of care in their unit/area, just over 68% of participants reported that agency use had an impact (Table 41). When asked to describe how, participants could provide more than one response. Similar to patient safety, challenges related to short-term contracts and limited time on units were reported in close to 83% of the responses, specific to new staff not being familiar with resources, patients/clients/residents, or able to follow care plans long-term. Just over 9% of the responses also reported lack of familiarity with information reported during handover at shift change which impacted the patient information provided from shift to shift. Over 7% of the responses also reported that continuity of care was improved with more staff.

Interviews with employers from facilities where agencies are used

In the interviews with employers from facilities using agencies, participants were asked if they were aware of any data being tracking to determine the impact of agencies in their facility. Two participants reported tracking through staff engagement surveys every two years, or during forums/meetings with nurses. Others described the challenges of tracking due to multiple factors contributing to potential impact variables. For example, difficult to identify what contributed to improvement in falls or staff satisfaction as many factors can contribute to this, not only the use of agencies. Next, participants were asked how the use of agencies

Table 39
Impact of agency use on morale of permanent nursing staff: surveys completed by managers and nurses working in health care facilities which use agencies

	%
Has the use of agencies impacted the morale of permanent nursing staff?	
Yes	80.4
No	19.6
If yes, please describe how.*	
Permanent nurses feel devalued, demoralized and exhausted	53.6
Permanent nurses feel a lack of a 'team' or team building with frequent new staff	34.9
Permanent nurses have improved morale with more staff, less overtime, less mandates, vacation time	7.8
Permanent nurses want to quit or leave or already have	3.7

*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Table 40
Impact of agency use on patient safety on unit/area: surveys completed by managers and nurses working in health care facilities which use agencies

	%
Has the use of agencies impacted patient safety on your unit?	
Yes	69.3
No	30.7
If yes, please describe how.*	
May be unfamiliar with policies, protocols, routine, care standards, local scope, paperwork	40.3
May not have enough experience in clinical area or adequate orientation	27.5
Challenges with short contracts and limited time in areas: LTC residents not familiar with nurses, anticipation of long-term issues, follow-up if questions after shifts	19.7
Better patient safety with more staff	12.5

*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.

Table 41 **Impact of agency use on continuity of care on unit/area: surveys completed by managers and nurses working in health care facilities which use agencies**	
	%
Has the use of agencies impacted the continuity of care on your unit?	
Yes	68.3
No	31.7
If yes, please describe how.*	
Challenges with short contracts and limited time in areas: not familiar with resources, patients, following care plan long-term	83.2
May be unfamiliar with information to report during handover at shift change	9.3
Improved continuity of care with more staff	7.4
*Participants could provide more than one response. Therefore, the percentages equal the number of responses for that category divided by the total number of responses for all categories listed.	

had impacted their facility. Responses were grouped based on positive experiences, impact on team morale, performance management, quality of care, workload of nurses and workload of facility's leadership.

1. **Positive experiences**
   One employer participant discussed the positive experiences within their facility and outlined the importance of 'putting thought' into the decision of using agencies with an emphasis on working with only one agency to ensure the experience is positive. Below is a quote from this participant to expand on this.

   > *"… our experience has been overall positive, you know? And I think the structure we put in place – and I think later securing agency, we put thought into it with the decision and how we need to make this successful and we want to. Because it's not just about putting a person in a unit and on a line… we were very clear that we're not going to have our nurses come back as agency nurses. And you can be criticized for that, but you have to make those decisions."*

2. **Team morale**
   Employer participants described the 'destabilizing effect' that the lack of continuity in a team can have on the team's morale. Below are two quotes from employer participants to expand on this.

   > *"… as far as having that, continuity in the team in terms of having that base knowledge that an experienced team can develop together… there's a different investment in terms of mentoring new staff who are taking on a regular line [where] that mentorship will pay off in the sense that it will stabilize the team over the mid and long term. Whereas when you're doing that same level of investment in terms of mentorship and orientation with new staff coming through that are [not] familiar with the facility, they might be here for 3 shifts. They*

might be here for 3 months, but regardless that investment is very short term. It does have a destabilizing effect on the morale of the team."

"… the morale of staff, I think, is implicated when people don't feel they have enough of their own, enough of their own staff members coming in to be on shift with them."

3. Performance management

One employer participant discussed how the use of agencies created a different relationship with clinical and operational leadership when the facility doesn't have the same degree of ability to oversee or follow up directly with a nurse working with an agency to address a clinical practice concern. Below is a quote from this participant to expand on this.

"… it outsources our ability, as an employer, to manage all the things that an employer traditionally would be, like around maintaining quality managing. We're completely reliant on a private enterprise which I don't have many sightlines into how they are run, how they are regulated. Doing all the background checks and screening appropriately and following up is needed when there is a competency or practice concern. Yeah, there's not clear process there, and that leaves the system really vulnerable." For example, "[When] there [are] concerns about practice… if it was regularized [staff] we'd have a very clear pathway to coach and mentor… and then, if needed, move into a performance management scenario that would be supported and really clearly documented and seen through. Whereas with an agency staff, all we can do is really report back to the agency and decline to take that nurse back if it's egregious enough of a concern. But then we're relying on the private agency to do their own follow up and we don't get clear loop back on what their outcomes are there."

4. Quality of care

Another employer participant discussed having less influence over nurses working with agencies, and concerns over the quality of care specific to the lack of familiarity with the system, environment and teams. Below is a quote from this participant to expand on this.

"… I think we have less control over who – obviously they have a minimum standard, and they come to us with a minimum standard, and we can expect them to function at a certain level. But we don't have as much influence, I would say, over, and we don't avail them of the same opportunities for learning and development, and they're not always as enmeshed in the team in a way that's positive. I think financially, obviously that's a consideration as well. We want to be careful… I do have a concern about quality of care, and that relates to knowledge of the system, of the environment that you're working in, the partnership and engagement with the teams…"

5. Workload of nurses

Employer participants discussed the increased workload for permanent nurses due to the constant turnover and new team members. Below are three quotes from participants to expand on this.

"… nurses coming from agencies do not always have the same level of education or knowledge of how our system works. The people, the processes, the technologies, the way we do things. And at times, they can be quite dependent on the employed nurses. Well, help me understand

this machine. Help me understand how to process this form. Help me prepare this patient for discharge. How does it happen here? So, that is a lot of work for the nurses."

"… one of the reasons that [permanent nurses] feel committed to our site is consistently about the strong relationships that they have with their colleagues. And so, when we have this large percentage of the care team transient coming and going, it really erodes that. And we hear that from staff over and over again. So, there's both a feeling of, yes, we need them to come to be able to not be working chronically short. But, on the other hand, it's creating all this extra workload. It's viewed, it's perceived as though they have additional advantages over regularized staff in terms of having that flexibility, seemingly, that they're paid more. So, it just feels like an inequity, and that the regularized staff are left to pick up the grunt work of having to do that much orientation."

"… in some cases, unremunerated workload that's just sort of brought in under the general umbrella of 'what we do in a day'. Yes, under the umbrella of being a nurse on the floor that day and so that introduces resentments and certainly challenges."

6. Workload for facility's leadership

One employer participant working in a rural facility discussed the significant workload burden for their leadership team due to agency use in their facility, which included the increased number of orientations. As a result, their facility needed to create a new administrative position to manage the agency turnover. Below is a quote from this participant to expand on this.

"… that's a part of the workload with just evaluating the scheduling and making sure that we're bringing in contracts for the right intervals. Then the other layer to this is there's a lot of backend administrative work with this, because we also need to manage all of their travel and accommodations. Our housing and rental market is very challenged and so as a result, we've needed to step into territory that you know, typically a hospital site, and certainly health authority, hasn't typically operated in that space – maintaining lease agreements and housing stock to manage the rate of turnover we have with transient staff." "I've created a new administrative position just to manage our agency turnover. So, that would include our scheduling, the back and forth with the private agencies, as well as managing all the housing turnover. Kind of like lease agreements and related contracts like cleaning contracts and so on. So, we've had to create a whole new position that didn't exist before to support that. And then we also have my clinical coordinator. So, our clinical nurse lead, who's also very closely involved with managing the staffing and the scheduling and all of those implications. And then our [clinical nurse educator]. I've actually had to bring on additional workload [clinical nurse educator] hours to support the amount of orientations. There's tremendous workload there in terms of managing, incoming, and outgoing staff at that rate. So, there is quite a significant burden that that creates for our nursing leadership as well…"

Interviews with nursing leaders

In the interviews with nursing leaders, participants were asked how the use of agencies has impacted nurses' morale, patient safety, teamwork, and continuity of care. Additional areas discussed by participants include performance management and loss of mentorship.

1. Nurses' morale

Nurse leader participants discussed the impact on permanent nurses' morale when working alongside other nurses making more money including having their travel and accommodations covered and receiving preferential schedules, assignments and education. Below are quotes from participants to expand on this.

> *"… one of the other negatives is the staff morale. The fact that it's often the core full-time staff who are actually training agency who make triple what they're making… and the full-time staff are also precepting students and so on. So, it creates this fracture in the profession of colleagues working alongside one another. But you can't help but have some animosity given those pay disparities."*

> *"… there was a… inpatient unit, and they wanted to do some cardiac basic education, telemetry, monitoring. And [nurses] were seeking this education and being denied, and they offered it to the private agency nurses… it was very, very demoralizing, very disruptive, agency nurses getting overtime ahead of [permanent nurses]… casual employees not getting any shifts when we were using agency nurses, their availability."*

> *"And what we're seeing as well is that… agency nurses are receiving preferential shifts and preferential patient assignments… because of the contract they have, [nurses from agencies] are not rotating shifts, as other nurses would." "They are not floating about, and [permanent] nurses are floating around the facility because the agency nurse might be hired to perform duties in the ICU, only in the ICU, and if the employers deemed it's overstaffed, they are floating now their own staff around the facility which is impacting continuity of care in the home unit. So it is, and again, that demoralizes the staff that are there."*

2. Patient safety

Nurse leader participants discussed the impact on patient safety with facilities restricting or limiting access to technology, such as Omnicell and Pyxis machines which affects medication administration and documentation systems, such as Epic and Cerner, which lead to delays in documentation as nurses working with agencies must either resort to manual/paper or other colleagues need to complete the documentation for them. If other health care team members are unable to access documentation or the documentation is not up to date, this can lead to patient safety and care issues. Below are quotes from participants to expand on this.

> *"… when you look at employers in critical care in particular, that's a good example, are looking for ACLS or TNCC or ENCC credentialing, PALS, PEARS, all of this credentialing, and not every agency nurse has that, or they haven't shown proof that they have that." "In addition, we're hearing this all over, that around Omnicells and Pyxis machines that they're not always allowed to take out the same level of medications as a staff nurse, that they*

require a witness for more things that they or, in fact, they can't get in the machines at all. So, there's delay in medications, you know, as you add more folks at those machines, there's an increased risk for medication errors."

"And there were agency nurses that were working on the floors, and they couldn't use the system because… they didn't get access codes. And so, they're expected to come in and fill a vacancy of a nurse on a floor that day but they can't administer medication because they can't get into the Omnicell or the medication cabinet. Because they're not going to go through the trouble of giving them a passcode for one shift. Or they come in and they've had no orientation on how to use the charting system."

3. Team cohesion and continuity of care

When discussing the impact on continuity of care, nurse leader participants discussed how all nurses strive to provide quality care but there can be difficulties with providing continuity of care. They linked this closely with teamwork and understanding the nuances of team members, as well as knowing policies, expectations of the facility, the patient/client/resident population at the same level as a permanent nurse, and the community context. Due to the transient nature of agency contracts, continuity of care is challenging, and often falls back on permanent nurses to ensure the expectations are met. In addition, in some provinces, nurses working with agencies have their scope of practice limited by the facility which is an additional challenge for the team. Below are quotes from participants to expand on this.

"… in a normal practice environment, you would be on a schedule. You would be part of a team you would work with Continental shift, or the day day night night or Monday to Friday, depending on your unit or your facility, and you learn to work with each other. You know the expectations of the organization, of the community. You understand the patient population. Quite often, you know patients, because you see them regularly… So, when you have someone who's transient, they don't develop the same relationship with the facility, the health care facility, the patient population and within the team as well. So, the continuity of care is affected."

"… makes it difficult to create a plan to have that continuity of care, to have different people coming in and out on a continual basis, not understanding the workflow, not understanding the culture, not understanding, or having any sort of relationship with any other team members outside of the nursing team that you'd have to try to work with."

"… the challenge… is not knowing the unique context and circumstances, which care is relational. And yes, it's competent and it's skilled, but it's the relational aspects of care, knowing who your colleagues are, knowing who you call in an emergency, who are the physicians who you can rely on. And even the local context, the patient context in some environments is also the cultural safety. And so not having that, you're brought in and the risk is that you're… just filling holes in the system. I think that's how it's perceived, that nurses are brought in to fill holes in the system. I don't want to cancel ORs. I don't want to close emergency departments. So I'll bring in agency nurses. But it's not as simple as that. You need [nurses] who actually understand the context in which they're working."

"… for patients, it's the lack of continuity and that you are seeing potentially different faces every day. Sometimes that can be the reality that's inherent in our current workforce. But I think when you come in and you may be a new face, but you still – you don't know the organizational environment. You don't know the physicians. You don't know who to call. You don't know the policies and procedures that creates a lot of angst. And I think whenever [nurses] are needing to receive health care, it's often not their best day. And so not having that sort of institutional knowledge is, I think, a great detriment to patients."

"… it's just that when you don't understand the culture of one hospital and you change different hospital in urban, you will face different cultures. And this is… what I observe is the use of agency increased the workload of nurses because they've been asked, "Where is this? Where is that? Where I can find this?" And they don't understand the cultural reality of the organization in some way."

"Within some provinces, agency nurses do not become a member of the team as they have a very narrow scope compared to regular staff: "They are drop-ins that come and go."

4. Performance management

One nurse leader participant raised concerns about the process followed by agencies when there was a clinical practice concern. This was also raised in the interviews with the employers. Below is a quote from this participant to expand on this.

"I think the other thing is if you have a nefarious practitioner, that would be tracked. I mean, they would probably 'let the agency know this person is unsafe to practice. But any reporting beyond that, I don't even know. So typically, if somebody is fired from an organization and it's because of performance, it's supposed to be reported to the regulatory body."

5. Loss of mentorship

One nurse leader participant discussed the lack of stability in the nursing workforce with the loss of experienced nurses who would normally mentor and support the professional socialization of new nurses, and how this is a detriment to patients/clients/residents. This mentorship may be lost with the use of agencies. Below is a quote from this participant to expand on this.

"… my mentors empowered me to be a leader in health care. They empowered me to take extra education. They empowered me to do all that from a very young age in nursing. And I would hate to see that gone. Because now I'm the age in nursing where they were when I started, and I see that a lot of us are leaving in my age demographic. A lot of us are burnt out. Lots are going to agency. And there's just not that stability, those matriarchs or patriarchs of nursing… and it would be to the detriment of patients, residents, and clients for that to be gone forever. And I don't think it's recognized as much as it should be."

14. What impact has agency use had on the public health care system?

In the interviews with nurse leaders and employers who use agencies, participants were asked how, in their roles, they have seen the use of agencies impact the public health care system. Participants discussed the disruption of the public system with the exploitation of public health care monies, the lack of transparency, oversight and accountability, the impact on rural and remote areas, the negative portrayal of nurses working with agencies, the eroding of public confidence in the nursing profession and public system, and the destabilization of the nursing workforce.

1. Disruption of public system with exploitation of public health care monies

Participants identified that agencies are disrupting the public system with a shift from public to private health care, pay discrepancies that can't be matched in the public system, nurses being drained from the public system, hospitals being forced to take out loans to sustain staffing levels, and rural and remote areas experiencing further challenges to recruit nurses. They also discussed how the high costs associated with agencies is not sustainable and how agencies are used is not transparent. Below are quotes from participants to expand on this.

> *"…in media you can see the hospitals have been forced to take out lines of credit, loans in order to sustain their staffing levels. That is not related to the unionized nurses. It's related to the fees that they are paying private agencies."* (Nurse leader participant)

> *"I really have a problem with the agencies who have taken the opportunity of our capitalist society and gouged the hell out of the public system by increasing the prices that they charge but three, four, 500 percent what we were paying when I first started using them years and years ago. And that's the piece that I find so appalling is that the agencies have taken such advantage of the situation that we're in."* (Nurse leader participant)

> *"And this is what we're up against in [province], with the inability to actually get ourselves off this drug of agency nursing. And what they never talk about too, is the fact that… the agencies get paid a significant amount of money per hour. We know that the people that are coming in get about X an hour, the agency gets probably three to four times that." "And we could take all that money, which we really could, and reinvest it back into a very vibrant retention strategy, mentorship strategy, incentivize mid to late career registered nurses with 10,000 bucks, "Will you stay for a year so we can stabilise?" There are so many things that we could do if [government would] actually sit down and listen."* (Nurse leader participant)

> *"… I would also say that the type, the way that agency nurses are used or agencies are used is not tracked. So, some, it's used as sort of a headhunting just to fill the vacancy, and others, it's used like you're actually remunerated through the agency. And so, there's various ways in which agency – it's, I think, helpful for organizations if they're able to say, "Hey, agency, can you*

find me an OR nurse and pay a fee to find an OR nurse, but then employ them through your hospital?" And that model actually exists in some places. So, I think the variety of ways is also not known." (Nurse leader participant)

2. Lack of transparency, oversight and accountability

Participants referred to recent media attention illustrating the lack of transparency, oversight and accountability by facilities and governments to agency contracts and overspending. Below are quotes from participants to expand on this.

"I would say is some of what we're seeing in the media right now about the contracts that governments and organizations have signed, some of the things like the Globe and Mail article was eye-opening." "The amounts of money that governments are paying and the lack of oversight and the lack of monitoring about whether the money was going or was supposed to be going. Whether it was appropriately spent, when we hear about the millions of dollars that went to these agencies that never even made it into the hands of the nurse that was supposed to get it is obscene." (Nurse leader participant)

"In some ways what's happened is the governments and the health authorities and the hospitals have not been transparent to the communities they're serving to truly let their public know what they're capable of doing and what they're capable of offering. And where I've seen a difference, is in the far north. Those organizations have made difficult decisions to not provide services that they could not safely, consistently provide and made arrangements for people to go south for care. And you don't necessarily see the same approach down here." (Nurse leader participant)

"I think my overarching impression of this whole situation is that our over reliance on agencies is very reactive. There's not any degree of oversight, or regulation or overarching strategy around getting to a place where I mean, we will always need a flex layer in addressing staffing fluctuations across a region or area within any given site. But it's so reactive and so very reliant. And it really is privatizing health care in through the back door, right? Like it's not, like if you're running a hospital on 50% private agency, it introduces all kinds of challenges in terms of that oversight and ability as we have discovered. Ability to follow up on performance challenges and general risk management and so on… I don't see coordination yet across the system to really make a meaningful indent. And I think it's just the general HR shortage and it doesn't set us up well to address it in ways that would be long-term fixes. Long term fixes are needed here." (Employer participant who uses agencies)

"When we really started to work with the government on HHR and I said to them that during the pandemic you put limits on what people could charge for PPE and hand sanitizer. Yet, you've not done the same on what these agencies can charge the health system to try and support it to keep service provision for the public. And we told you it was coming, and you needed to do something about this. Why can you do it for one of these situations and not the other? Because fundamentally, what you were trying to achieve with one is exactly what we should be trying to achieve with the other and they never ever bothered." "But they could have legislated some cap on what agencies could charge the health systems across the country for this service." (Nurse leader participant)

"There has to be more oversight. These contracts that were signed that you can't poach me and I can't poach you, who was thinking in their right mind that that was going to improve our health care system? That a nurse in [province] that came to work here with a private agency, and decided, "You know something, I like this province, I'd like to actually take a permanent job there," are prohibited from doing so because of a contract with a private agency for upwards of 12 months. So those clauses can never be in a contract ever again. I've actually heard that it actually goes against a new federal legislation about competition." (Nurse leader participant)

Building on the last quote, media articles also outlined how some agency contracts have restricted nurses from returning to a province's public health care system for a required amount of time. Quinn (2024) identified that four to five agencies have clauses in their contracts that prevents some nurses from staying and working in the province's public health care system for 6-12 months after leaving an agency. It was noted that one agency's contract required a nurse to be disconnected from an agency for more than a year before they could work in a province. If breached, the province paid a hefty fine to the agency - between $5,000 or a full year's salary. Similar clauses also appeared in agreements in New Brunswick, with the contracts being even more restrictive, by stating that nurses sent by an agency could not work for a specific health authority for two years after the contract ended (Ha & Grant, 2024).

3. Impact on rural and remote areas

Participants described how the original intent of agencies was for supporting rural and remote areas where it was, and continues to be, difficult to recruit and retain nurses due to geographic challenges. During COVID-19, agencies were introduced as a short-term solution everywhere but are now being used as a tool to staff routine needs in facilities. The increased use of agencies in urban centres 'in the south' has made it more difficult for rural and remote facilities to recruit due to competition for agency contracts and fewer resources to compete. Below are quotes from participants to expand on this.

"... [organizations have] taken what was supposed to be a short-term, brief lever that was to be used at the last minute, extreme circumstance and it has become normal. And it had become a tool to ... staff routine needs in hospitals and other organizations. It's not being used as it was intended to be used when we first started using them. And so, regions of the country that I think are the most impacted, definitely rural, remote. And when they were first – like travel nursing first erupted in the health system in Canada, it was largely the far north that were using them. Because they just did not have the ability to recruit people to some of those isolated rural communities for long term." "And then what I saw is that it evolved to the point where they were starting to be used in the south, largely in specialty areas." (Nurse leader participant)

"I would say the rural region and the remote region, that's the most difficult part of it. I know that they use agencies since so many years" "We've seen, since so many years the use of agency, they have difficulty to keep people there. There was a lot of, there was considerable turnover." (Nurse leader participant)

"From what I have heard it has made getting staff even more difficult [in rural and remote regions]. Because there are organizations that have limited funds. They're not as big as some of

these great big hospitals and health authorities down in the south. And it is breaking them to have to compete with what the organizations down in the south were willing to pay to get these agency nurses. And it has drastically impacted those organizations fiscally." (Nurse leader participant)

4. Negative portrayal of nurses working with agencies

Participants discussed concerns about nurses being blamed in the media and by others for the current situation instead of identifying the structural systemic issues that need to be changed to improve the health care system. Below are quotes from participants to expand on this.

"We can't be demonizing them because they're nurses with great skills. They're doing the best job that they can in the situation they're in and I think they give good care." "… any individual nurse that is making a choice like that is doing it for a specific reason. Whether it is a life experience, whether it is removing themselves from a situation that is unpalatable, they can no longer stand, which we hear that is a lot right now." (Nurse leader participant)

"… what is, I think, concerning is the media is sort of blaming this issue as the nurse made this much and the nurse got this much for meals and travel. And these are entirely structural issues that require structural change. So, we really ought not to blame the individual nurse for these structural systemic things." (Nurse leader participant)

"… as a professional we should not disparage or make unkind comments towards agency nurses. I mean, they are professional as well. And that's something that bothers me, because fair is fair. If I were an agency nurse for whatever reason, and I'm a nurse, and I think I did really good patient care, and I understand that. But I think it's unfair that they get treated unfairly or unkindly. I mean, they are providing a service that an organization has made a decision." (Employer participant who uses agencies)

5. Eroding public confidence in the nursing profession and public system

Participants expanded on the negative publicity by describing how it is eroding the public confidence in the nursing profession with the notion that nurses are 'just plugging holes'. Below are quotes from participants to expand on this:

"I think it's eroding the public confidence in the profession overall… first of all, there's so much negative publicity, but also this notion of nurses just plugging holes in the system instead of elevating us as a profession to being valued members of – valued health care providers. And yes, we're employees, but we also have basic needs that other industries have completely figured out. They figured out how nurses can have time off, how nurses can have adequate rest, adequate nutrition, parking subsidies, transit subsidies, housing. These are not foreign concepts. But for nursing, it's just like, yes, these things don't often exist." And "… this notion of just putting nurses to work and plugging holes with nurses is so demeaning. And that's kind of the narrative that has persisted in the media instead of an autonomous. And I think nurses are like, we'll show you how

autonomous we are by going and carving out their own employment schemes that that work for them. And who can blame them at the individual level?" (Nurse leader participant)

"It's heavily impacted the economic state of our health system because of the amount of money that has gone into paying for those services. I think it's drastically impacted the confidence that the public has in the system and in decision-makers." (Nurse leader participant)

6. Destabilization of the nursing workforce

Lastly, participants also discussed how the use of agencies and nurses leaving the public system has destabilized the nursing workforce. Below are quotes from participants to expand on this.

"… it destabilizes everything, we don't have a stabilized workforce, we can just rely on people dropping in and dropping out, and I think that's the worst thing of all, is the incredible destabilization that we see happening, and you can't put too fine of a point on continuity of care, because we need – When people come in with extreme illness, and it might be a chronic illness that's become acute, and we're not there just to treat the acute episode. We need to actually follow that person to control their chronic illness, so we don't land them back in the emergency room again. And you can't do that with an agency nurse workforce… There is no investment back into the system that we need in [province], we are just earning money and sending it out of province and not doing anything to stabilise the workforce, stabilise the health care system, and to find our way down a different road, the return on investment and what we're doing now, is in the minuses." (Nurse leader participant)

"At the structural level, the system needs to change. We have more nurses than we've ever had in Canada, yet many are leaving the profession, leaving the public sector, the conditions in the public sector are just unsustainable." (Nurse leader participant)

15. What strategies and initiatives are being used in health care facilities to retain nurses and ensure agencies are not needed?

In the interviews with all employers, participants were asked to discuss strategies and initiatives that their facilities used to retain nurses and ensure agencies were not needed.

Interviews with employers from facilities where agencies are not used
In the interviews with employer participants working in facilities who have never used agencies, they identified their strategies and initiatives used specifically during the past three to four years to retain and recruit nurses. Both reported that the vacancy rates in their facilities decreased or stabilized with these initiatives, with some challenges remaining in the ED. Below are quotes from participants to expand on each of the initiatives listed.

1. Increased the operational budget to pay nurses' double overtime

"So we made the conscious decision to pay double overtime to our staff. And we very clearly signalled that it was because if we were short-staffed, I would rather pay our staff more money than pay agencies more money. So we probably spent just as much on our own staff as we would have if we had used agency but felt better about it from my perspective."

2. Doubled education budget to provide nurses with opportunity to attend conferences or take courses to upgrade skills

"… the investment that we made was we actually doubled our education budget. So we have a certain amount of budget every year for staff members to advance their skills, attend a conference… and we actually doubled it… so that we could say to our frontline staff," "If you want to attend a conference, if you want to attend an education day, if you want to" – because there was lots of things being offered…" "So instead of us signing on someone to come to the hospital, we thought that investing in our own staff and building the retention culture would be a better benefit for us."

3. Used a collaborative approach to navigating staffing challenges

"There were, earlier it was twice a day and then it moved to once a day, but leaders would have a call once in the morning, once in the afternoon, eventually just once in the afternoon, to talk about staffing across the organization and where people were anticipating gaps in the scheduling that day or that night, or for the next 12 hours or the next 24 hours. And then

they would work together to try to shift folks around where they could, so that we would be making decisions about staffing… using a collaborative approach to try to navigate some of these staffing challenges in the midst of staffing shortages without just calling an agency and saying bring another nurse."

4. Developed a 'pipeline' of nurses to fill staffing vacancies

A. Hired health service aid/assistants, internationally educated nurses.

B. Focused on nursing students by hiring externs, creating clinical care assistant roles for hiring students finishing final consolidation and before new graduate initiative could be applied, increased clinical learning opportunities.

C. Created part-time positions to allow for work-life balance/vacation/days off.

D. Used Ontario Community Commitment Program for Nurses (CCPN) which provides $25,000 in grant funding to eligible nurses in exchange for a two-year commitment to an eligible employer.

"… we have worked with our leaders and our educators to really be clear with them that nursing students are our next employees and you treat them well, court them, all of those kinds of things. So we do tours… if you haven't done a rotation in this unit, but you're interested, here's a tour. We have a lot of clinical interns, like we've taken advantage of the provincial funding, externs. So we've used every tool that the province has provided and focused very much on our students and capturing them, hiring them straight out of school and then developing."

5. Improved scheduling flexibility

"So, I think one of the other aspects that we really started to focus in on was building our pipeline and then what are those other irritants, what's the glass in the shoe for our frontline staff. Schedules was their biggest irritant, biggest irritant. And so we started looking to do things like building in relief so we could get more nurses off on vacation. Changing to an innovative schedule and tailoring it. So instead of just the whole entire hospital on two-day, two-night, what could we do that would be easier for your group of nurses."

6. Started nursing development program to enhance knowledge and learning

"We also started… a new nurse development program that was basically a one-year, more intensive support. So, there was a central nurse orientation, but then a whole process of mentoring and opportunities for group learning and check-ins over the first year, additional types of educational opportunities within that new nurse development program. And we, because we were seeing that a lot of… our retention challenges were in the first couple of

years. And that hasn't disappeared, but we think it's gotten a little bit better with some of that additional support through that new nurse development program."

7. Developed new models of care where feasible

"So, when we stood back and looked at that, we knew that the registered nurses were under significant pressure being constantly interrupted and having the sickest patients and being asked to do things like give an IV med when it was in the [LPNs]' scope of practice. And those [LPNs] were frustrated because they knew they could do more; they didn't feel like they were working to their full scope of practice. So that was one of those a-ha moments for us that we recognized that we had an opportunity to actually utilize our internal workforce and team to decrease that workload on the nurse, so that would help them, and increase and empower the [LPNs] to work to their full scope of practice. So, we started that work quite early."

8. Changed hiring process to a collaborative model

"… we started to look at like-portfolios [where] we would block the managers [time] in medicine. So, there was like three managers for medicine and what they would do is they would block two hours. Each would take a day and if there was somebody who met the criteria for medicine, they would interview them whether it was for their unit or not. So we had to build that trust within the managers, right, that they trusted that they were going to be interviewing someone. And so being more nimble made a huge difference on those hiring processes."

9. Implemented unlimited health and mental health benefits

"Another strategy that we implemented… has been received extremely well and is completely founded on multiple persistent requests from staff through a variety of surveys and other means of hearing their voice. We just recently implemented unlimited mental health benefits. And that I think has been, and will continue to be, something that will be a strong retention and recruitment point for us as an organization and will increase the wellness of our staff for sure. So a really important move, I think, in supporting our staff and in helping to stabilize our workforce."

Interviews with employers from facilities where agencies are used

In the interviews with employer participants from facilities using agencies, they reported that their key strategy was focusing on retention and recruitment initiatives by creating an optimal work environment in the facility. Examples included relocation assistance, sign-on bonus for 2-year commitment, hiring internationally educated nurses, hiring a dedicated clinical learning specialist, removing administrative or other non-nursing tasks, mentoring programs, clinical scholar program through provincial initiative, re-establishing shared-governance

models, wellness programs, cross training nurses to build capacity (upskilling), offering tuition support, adapting models of care, implementing nurse-led and NP-led clinics, and developing a charge nurse training program. Below are quotes from participants to expand on each of other initiatives also identified.

1. Retention and recruitment committee

"There's a nursing engagement, retention and recruitment committee, which is corporate that I chair, and then frontline nurses participate. At the local level, you always want for them to be doing things."

2. Referral bonus where staff recommend friend

"… one strategy that we have there with that is that we did have a recommend a friend model. So, if nurses recommended a friend, a colleague, to be hired, and that person was hired, we also had a recruitment bonus for those individuals to share. That has actually proven to be a very effective method for recruitment."

3. Nursing students paid when completing consolidation in final year

"… what we started is the fourth-year consolidation students, so through university, baccalaureate, are having a paid consolidation. So when their final consolidation, with the goal that they're integrated into medicine, they like it, and then we would hire them. We've had some really good success with it, but we learned a few lessons there. We had almost X, and I think about 60 percent have signed on for a job, which is good in the medicine areas."

4. Build internal resource pool

"Many of the, particularly the novice nurses who are coming to be members of a nursing resource team, they are amazing. They're curious. They want to learn. They're agile and flexible. They like going to different units because they like meeting different people, learning different nursing interventions. They like working with different populations of people. So, I think we have to collectively reframe. It's not just filling a gap. It's not the nursing pool that we're just picking someone today because we don't have enough staff. I think we have to really invest in this group and build a robust and flexible team that actually really enjoys having this degree of variety in their life and enables them to have a more flexible control over their schedule. So, that's another thing nurses are asking for all the time is flexibility in their schedule. And we have some work to do on that too. We're not there yet."

Rural and remote settings

Challenges were identified by the participants working in the rural and remote facilities, specific to geography making retention difficult, and a lack of funding to offer signing bonuses or double overtime like other sectors. Participants discussed that unions limit some retention strategies as 'everyone must be treated the same', and that nurses only stay because they are from the area and have limited options for employment unless they want to travel. Another participant who works in a province with a provincial staff agency reported that it is starting to make a difference, but they have had limited options to recruit and retain permanent staff. Below are quotes from participants to expand on this.

> *"Well, we are unionized, so basically the government funds us. And we can't offer, because we are small, like the [we are] smaller than the [larger health authority in the province] and the hospital sector, they offer bonuses to hire new employees. We can't do that because we're not funded for that. To retain the ones that we have here, I mean."*

> *"And so, the effort with [Provincial Staffing Agency] was to level the playing field by keeping nurses in province and under the collective agreement. So it creates a bit more evenness across the team." "We are the latest rural site to be brought on to that provincial program and it's making a bit of a dent. It is not running at capacity yet, that it could fully replace private agency. But it is starting to make a little bit of a dent like we actually are sitting down as a scheduling team and looking at it and saying, okay, maybe we actually don't need this private agency contract for this specific time period." "… and the boon for us in operations is that they take care of all of the travel and accommodations. They manage, they accommodate, the leases for any of their [provincial staffing agency] nurses that are coming our way. So it really reduces the administrative and certainly the operational expense running it that way."*

16. What provincial/territorial initiatives have been implemented or brought forward?

To identify strategies or initiatives taking place provincially or territorially to reduce or stop the use of agencies, data was obtained from media articles and interviews with nurse leaders.

Interviews with nurse leaders

While most nurse leader participants reported that they were aware of initiatives related to recruitment strategies, such as signing bonuses, most indicated that they were less aware of strategies or initiatives to retain nurses at the provincial level. Participants reported that some governments were not receptive to suggestions and recommendations. Below is a quote from one participant to expand on this.

> *"We've met with [government]… with ideas because we are always ready to collaborate to figure – because registered nurses do have answers to these issues, they live it every day, so they should be the people that are being spoke to. We've floated out and brought a whole bunch of research and evidence on a really vibrant mentorship program, that you actually have to invest money and resources, human resource into. We've brought studies about a nursing task force*

because they've done it across the country, and we've brought examples of incentivizing registered nurses, and a return for service to stabilise the workforce, and it's all fallen onto deaf ears."

The provincial strategies and initiatives that were identified to retain nurses included:

- A project to help staff rural and remote areas.
- Self-scheduling to increase flexibility and control around schedules for staff.
- Increased wages and incentives.
- Bonus for permanent full-time positions.
- Double pay for overtime
- Financial support for tuition for students and paying students for their final integrated placements
- Childcare seats dedicated to health care workers.
- Come home bonus.
- Coordinated key stakeholders coming together to discuss nursing issues and education requirements – exploring expedited nursing programs.
- Increasing education seats and shortening the education programs.

"The self-scheduling, we've had a lot of areas that have been very resistant to doing the self-scheduling, for instance, HR scheduling departments and that." "Once we've introduced that in certain areas everyone, even management, and HR are all in agreement, "Oh, my God, this is making a difference." "And we're able to staff the area better than we were previous to instituting self-scheduling on a unit or in a facility." "The increase in seats at schools of nursing. We're not going to see that for another four years, but we will see more people graduate and hopefully take positions here." (Nurse leader participant)

Media articles

The review of media reports provided further information regarding government legislation or initiatives that had been announced. A brief summary of each one is outlined below by jurisdiction.

British Columbia

GoHealth BC is a collaborative effort between Northern Health, Interior Health, Island Health, the Ministry of Health, and the British Columbia Nurses' Union to create a flexible approach to serving rural and remote communities. The program allows nurses to expand their scope of professional practice and take on new experiences. The GoHealth BC program operates through Northern Health to support eligible communities in Northern Health, Interior Health, and Island Health with plans to expand to additional communities and health authorities throughout British Columbia (GoHealth BC, 2024). Offers permanent part-time and casual positions to RNs, RPNs, and LPNs with a minimum of two years of

acute, LTC, or specialty experience. Provides all flights, car rentals or Northern Health fleet vehicles, ferries, or a mileage equivalency; meals per diem; and accommodation typically with a kitchenette. Family members (spouses, children) may be able to accompany to some locations determined on a case-by-case basis. Expenses of family members are not covered. Employees have access to collectively bargained employer paid extended health and dental benefits (GoHealth BC, 2024).

Newly hired nurses who are eligible when joining GoHealth BC can receive up to $15,000. This includes a $10,000 recruitment incentive with a 12-month return of service (ROS) commitment for newly hired nurses who work and hold certifications in ED, critical care, operating rooms and maternity, and are hired to regular positions, in which they are scheduled to work in those designated service areas as part of their regular rotation. In addition, if a newly hired specialty nurse works 1,500 productive hours within the 12-month period from the date of hire, they will also receive an additional one-time $5,000 retention incentive (GoHealth BC, 2024). Newly hired nurses working in other specialties who are hired to regular positions will receive a $5,000 recruitment incentive with a 12-month ROS commitment and if they work 1,500 productive hours within the 12-month period from the date of hire, they will also receive an additional one-time $3,000 retention incentive (GoHealth BC, 2024).

Alberta

The RN/RPN Locum Program is focused on providing staffing for facilities and programs operating in the North Zone of Alberta Health Services for short term periods of less than 12 months. Placements typically run approximately three weeks, however, the time frame is flexible with no formalized minimum or maximum duration for placements. The location is negotiable across over 40 communities and 115 sites. Locum assignments are based on experience, specialization, availability and location preferences (Alberta Health Services, 2024; United Nurses of Alberta, 2022a).

Locum nurses may receive additional incentives including:

- Temporary premium payment of $25.00 per hour on top of regular wage.
- Temporary daily payment of $50.00 for each day of assignment if outside the cities of Grande Prairie and Fort McMurray.
- A per diem allowance of $25.40 for each day on assignment.
- Reimbursement for travel costs.
- Accommodation provided by the program at no cost (Alberta Health Services, 2024; United Nurses of Alberta, 2022a).
- Benefits in accordance with the collective agreement based on work status and length of assignment. For example, temporary employees who accept a locum assignment of greater than three months and less than six months are eligible for supplementary health benefits and dental benefits. For regular employees accepting a locum assignment of greater than one month, benefit premiums and entitlements are adjusted to the FTE of the locum assignment (United Nurses of Alberta, 2022b).

Manitoba

1. Initiated at the end of 2022, Manitoba governments' provincial nursing pool provides nurses with flexibility in terms of length of assignment, choice of health region, work location and specialty area (Manitoba Government, 2023; Sanders, 2023). Nurses are paid for travel time within the province, mileage, per diem and accommodations if needed. Nurses earn an hourly premium when assigned provincial float pool shifts, with casual employees having the option to join pension and benefit plans. They also have access to the same clinical and educational supports that regional nurses in the public system receive. Since the provincial nursing float pool launched in 2022, it has hired 160 nurses with more than two thirds (69%) returning from private agencies (Sanders, 2024a).

2. Recently, a new tentative four-year contract included a clause that prohibits nurses working for agencies from also picking up extra hours through the public health care system in the same health region. Under the tentative agreement, a health care facility that doesn't have enough nurses will eventually no longer turn to agencies first, but instead be able to rely on a provincial float pool of nurses, once that pool is sufficiently staffed. The tentative agreement includes additional payments for full-time nurses, and part-time and casual nurses who work up to full-time hours, who will receive a $12,000 per year incentive starting in April 2025. The incentive will be a two-year trial and could be extended if it results in decreased overtime hours and reliance on agencies (Adamski, 2024).

   According to the memorandum of understanding, the employer commits to making "best efforts to minimize to the greatest degree possible" the use of nurses employed by agencies to fill occasional available shifts, Such shifts, including those resulting from not filling term or permanent positions for a period of time, will be offered first to nurses at that facility in the public system. The side deal to the collective agreement also states that health regions "shall not retain or hire as an agency nurse," anyone who is also an employee of the health region (Sanders, 2024b).

3. The province is issuing a request for proposals for agencies to become validated by the province, allowing them to work with service providers in Manitoba. Manitoba has agreements with 75 different private nursing agencies that were signed by the previous Progressive Conservative government (CBC News, 2024).

Ontario

1. Bill 67: enacts the *Temporary Nursing Agency Licensing and Regulation Act*, 2023, put forward by Mr. Adil Shamji as a Private Member's Bill (Coppolino, 2023; Legislative Assembly of Ontario, 2023a). The Act proposed to add a new licensing requirement for operators of temporary nursing agencies. The applications must contain a credentialling and monitoring plan as well as a compliance plan. Licenses would be subject to several terms and conditions. These include a predictable fee requirement, a prohibition on unconscionable prices, limitations on work assignment and recruitment practices and certain disclosure obligations. Contravention of the Act or the regulations is an offence and is punishable on conviction by a fine (Coppolino, 2023; Legislative Assembly of Ontario, 2023a). First reading was February 23, 2023 and second reading was November 1, 2023. The vote was lost on division.

2. Bill 144: enacts the *Healthcare Staffing Agencies Act*, 2023. Co-sponsors: MPP France Gelinas and Wayne Gates as a Private Member's Bill (Casey, 2023; Legislative Assembly of Ontario, 2023b). The Act proposed that every hospital and LTC home in a municipality with a population of 8,000 or more shall develop a plan to limit its spending on health care staffing agencies in accordance with a specified timeline. Every health care staffing agency established after the Act comes into force shall operate as a not-for-profit. If a health care staffing agency receives more than $400,000 in total from the Government of Ontario or any of its transfer payments agencies, the health care staffing agency is subject to oversight by the Auditor General, the Patient Ombudsman, the Ontario Ombudsman and the Integrity Commissioner. The agency's employees are also included on the Sunshine List. A health care staffing agency shall not pay its workers assigned to a hospital or LTC home more than 10% above the existing rate in the hospital or LTC home for the relevant profession. A health care staffing agency shall not poach employees from hospitals or LTC homes (Casey, 2023; Legislative Assembly of Ontario, 2023b). First reading was October 31, 2023, ordered for second reading.

3. Other initiatives mentioned with little detail:

    A. Ontario is reviewing pricing practices of nursing agencies involved in LTC homes. Long-Term Care Minister Paul Calandra said at the legislature that his deputy minister had formed a technical advisory committee to examine the issue in response to queries about price gouging by nursing agencies (Casey, 2023).

    B. The Ontario Ministry of Long-Term Care is examining the possibility of creating a vendor of record for approved LTC agencies to potentially support price regulation (Jones, 2024).

    C. Liberal MPP Adil Shamji asked government to conduct a value-for-money audit on the impact of temporary staff agencies in health care. NDP government also called for the capping of rates charged to hospitals by agencies (Ferguson, 2024).

4. Beginning July 1, 2024, under the *Employment Standards Act, 2000* (ESA): Temporary help agencies are required to hold a licence to operate and clients are prohibited from knowingly engaging or using the services of a temporary help agency unless the agency holds a licence (Government of Ontario, 2024). In reviewing the website (https://www.tha.labour.gov.on.ca/portal/s/public-facing-status-page?language=en_US) which lists applications 'under review', there are 46 temporary help agencies with nursing or nurses in the legal or operating name and 131 with health care in the legal or operating name.

5. Two value-for-money audits by Office of Attorney General of Ontario.

    A. Hospitals in Northern Ontario: Delivery of Timely and Patient-Centred Care (Office of the Auditor General of Ontario, 2023a)

Findings specific to agencies

"Between 2018-2019 and 2022-2023, the use of agency nurses increased 25 times for hospitals in Northern Ontario compared to about two and a half times for hospitals in the rest of the province. At the northern hospitals we visited during this audit, we found that nursing agencies charged them about three times the hourly rate of a full-time hospital nurse, in addition to accommodation and travel costs. For 2022-2023, 29 of the 34 hospitals in Northern Ontario that responded to our questionnaire indicated that they paid about $78 million to private agencies for the use of registered nurses and registered practical nurses." (Office of the Auditor General of Ontario, 2023a, p. 2)

The report also discussed tools used to track staffing data in Northern Hospitals, including the Ontario Health North Workforce Profile Tool which "enables hospitals in Northern Ontario to create and maintain profiles for their current workforce, including nurses. Ontario Health would use this information to understand the vacancy and agency staffing rates across multiple sectors, as well as to forecast future needs and staffing pressures by geography and type of pressure (such as physician vs. nurses)." Ontario Health planned to fully implement this information tool by March 2024. (Office of the Auditor General of Ontario, 2023a, p. 62).

"Office of the Auditor General of Ontario Recommendation 5: To help increase the availability of nurses in hospitals in Northern Ontario, we recommend that the Ministry of Health:

- establish performance indicators and targets that measure the success of the Tuition Support Program for Nurses, and collect this data at least annually;
- evaluate the Tuition Support Program for Nurses at least once every five years and update the program as needed;
- assess the feasibility of creating a northern-specific program for nurses to help increase the supply of nurses in Northern Ontario; and regularly collect hospital spending data on agency health care staff by type of staff and share it with Ontario Health." (Office of the Auditor General of Ontario, 2023a, p. 23).

"Office of the Auditor General of Ontario Recommendation 6: To help increase the availability of nurses in hospitals in Northern Ontario, we recommend that Ontario Health:

- regularly monitor data on the costs incurred by hospitals for the different types of agency health care staff;
- explore the opportunity to leverage and align procurement of staffing agencies in the region, while ensuring that doing so does not add further risk to hospital service reductions and patient care in rural and remote hospitals; and, assess the costs of agency nursing versus what may be required to stabilize and retain hospital-hired nursing staff and share this analysis with the relevant stakeholders and decision-makers." (Office of the Auditor General of Ontario, 2023a, p. 24).

B. Long-term care homes: Delivery of Resident-Centred Care (Office of the Auditor General of Ontario, 2023b)

Findings specific to agencies

“Increasing reliance on agency staff was costly and reduced continuity and quality of care. We found that the average direct-care hours provided by contracted nurses and PSWs, including those supplied by agencies, rose from 4% in the first quarter of 2021-2022 to 10% in the last quarter of 2022-2023. We also noted that the reliance on agency staff varied significantly across homes, with agency staff contributing up to 50% of a home’s direct-care hours. By their temporary nature, agency staff were unable to provide residents with the same continuity of care as permanent staff, and some homes we visited noted that mistakes like medication errors tended to happen more frequently among these staff. Agency staff also cost significantly more than permanent staff, since staffing agencies are private for-profit companies and there is currently no legislation capping the amount that these agencies can charge homes. For example, based on our estimates, the average hourly rate for an agency registered nurse (RN) was $97.33/hour, which was 142% higher than the average rate of an RN directly employed by a home ($40.15/hour), with a portion of the difference retained as profit by the agencies.” (Office of the Auditor General of Ontario, 2023b, p. 2).

“Office of the Auditor General of Ontario Recommendation 1: To provide residents with high-quality care and to keep them safe, we recommend that the Ministry of Long-Term Care:

- analyze hours of direct care and staffing mix (that is, permanent staff versus temporary agency staff) at the home level to identify homes with staffing challenges, work with those homes on strategies to address their recruitment and retention challenges, and monitor the outcomes of the strategies;
- monitor staff-to-resident ratios, especially for periods that typically have staffing shortages (such as overnight shifts, weekends and holidays);
- complete the review of the use of agency staff in long-term care and implement strategies to reduce usage and prevent price gouging; and
- collaborate with the Ministry of Health in developing and implementing the long-term Health Human Resources Strategy to address staffing supply and compensation disparity issues across the sector.” (Office of the Auditor General of Ontario, 2023b, p. 19).

Quebec

April 2023, Bill 10: aimed at “prohibiting” the use of the services of personnel placement agencies and independent labor (MOI) in the health and social services sector. Complete ban by December 2024 for major centers like Quebec City and Montreal, and December 2025 for the rest of the province. Provisions for fines of up to $150,000 for failure to comply with the bill (Laberge, 2023). It was reported in May 2024, that the Entreprises Privées de personnels

soignants du Québec (EPPSQ), which represents private health agencies in Quebec, has launched a legal challenge to Bill 10 (Rukavina, 2024).

Fall 2023/April 2024: single contract signed by the government to meet the needs of hospitals and Centres d'hébergement de soins de longue durée (CHSLD). Quebec grouped all of the needs for hospitals and CHSLDs under a single contract which will now be managed by the Government Acquisition Center (CAG). This contract replaces the thousands of agreements signed over the years by health establishments, which until now negotiated their prices independently. While independent clinical nurses have previously received $150 per hour, the new maximum hourly rate will be $74 (Bellerose, 2024).

The province reached an agreement with the CSN union to allow nurses to maintain some seniority, meaning that if private sector nurses come back to work in the public system, they can start their new job with up to five years of seniority (Greig, 2024).

New Brunswick

March 8, 2024: New Brunswick Auditor General Paul Martin announced they are conducting an independent audit of the management of contracts pertaining to travel nurses, which includes the Regional Health Authorities, the Department of Social Development and the Department of Health (Ha, 2024a).

June 4, 2024: Auditor General's final report released: Between February 2022 and February 2024, travel nurse contracts were used to provide over $173 million of services in the Department of Social Development, Horizon Health Network and Vitalité Health Network. Their work found that a lack of clearly defined vendor selection processes, poor contract oversight and deficiencies in payment review processes resulted in undue risk to the province. Improvements in these areas will help ensure contracts protect the interests of the province and that processes are improved to ensure services billed are received. Overall themes were:

- COVID-19 exacerbated an already dire health care staffing shortage
- Poor documentation pertaining to vendor selection processes
- Noted risks to government pertaining to contract development, content and execution
- Lack of demonstrated value for money
- Inadequate oversight of contracts
- Lack of processes to ensure goods and services paid for were received

(Auditor General of New Brunswick, 2024)

Nova Scotia

December 4, 2023: Nova Scotia introduced a policy to limit the use of travel nurses that, effective December 15, 2023, the following changes were made to all government contracts for agencies:

1. Travel nurses working for Nova Scotia Health, IWK Health or a government funded long-term care facility can only be hired for a maximum 180 days.

2. They must wait one year before they can be assigned to work as a travel nurse for these institutions again. They may choose to take a permanent assignment in Nova Scotia or continue to work as a travel nurse in another province.

3. Nurses graduating from post-secondary institutions in Nova Scotia cannot work as travel nurses in the province for one year following graduation (Gorman, 2023; Government of Nova Scotia, 2023; Lapointe, 2023).

Newfoundland and Labrador

1. March 2024: Newfoundland and Labrador Auditor General Denise Hanrahan announced they will investigate contracts between private vendors and the province's health sector by conducting a performance audit, also known as value-for-money audits, to assess how programs are managed and focus on their costs, efficiency and effectiveness (Ha, 2024a).

2. February 2024: Newfoundland Health Minister Tom Osborne asked the province's comptroller general, who has oversight of the province's finances, to review Canadian Health Lab's contracts (Ha, 2024a).

3. Nurse locum pilot program: Launched in September 2022, the Nurse Locum Program allowed nurses already in the provincial system to fill short-term gaps in northern remote Labrador for at least two-week blocks. The program offers travel locum nurses an extra $25/hr for worked hours along with incentives that are comparable to those provided to agency nurses travelling to Newfoundland and Labrador. As a more cost-effective solution and a retention strategy, this program enables staff nurses to travel to other parts of the province to address staffing gaps and to also give staff nurses the opportunity to gain additional clinical experiences for professional development. Thus far, 100 staff nurses have participated in this program. While initially planned to last a year, the program has been extended until January 2025 (Kennedy, 2024; Labrador-Grenfell Health, 2022).

Northwest Territories

Discussion about re-establishing a working group between the Government of Northwest Territories and the nurses' union to identify when agency nurses should be used – and when they shouldn't. The government has also been asked by the union to provide an identifier for each agency nurse allowing the union to monitor such usage while preserving the employer's obligations regarding the disclosure of confidential information (Williams, 2024).

17. What more must be done to reduce the use of agencies?

In addition to the strategies and initiatives discussed previously, all employers and nursing leaders were asked during their interviews to identify what must be done to reduce the use of agencies. The following recommendations were provided by participants:

1. Publicly funded, government-run centralized staffing agency

Develop a publicly funded, government-run centralized staffing agency, similar to models currently in place in Manitoba (Sanders, 2024a), British Columbia (GoHealth BC, 2024), Alberta (Alberta Health Services, 2024; United Nurses of Alberta, 2022a), and Newfoundland and Labrador (Kennedy, 2024; Labrador-Grenfell Health, 2022) to provide avenues for growth, development and enrichment by allowing flexibility while helping with retention and recruitment. This includes sending nurses to northern communities under a public funded model. Below are quotes from the participants to expand on this.

> *"We're a publicly funded system, so why exactly would we not have said, gosh, we need a system that's going to send nurses to our remote hospitals, we need – so, act like an agency, but do it under public funding so that I'm not making some rich man sitting in some, excuse my language, but goddamn southern city wealthy. Like it is incredibly upsetting to me that we have not – the solution is right there. It's not hard."* (Employer participant who does not use agencies)

> *"… I am supportive of this move towards [provincial staffing agency] because it is a recognition that we're not just dealing with HR shortage. That's obviously the front and center issue. But it's also related to just changing demographics in our workforce… people don't want to work in the same way. And that's only going to increase with new generations coming up through into their careers. And so, we really do need to make these much broader system shifts in terms of the models of employment, so that they are more – we need to better understand and respond to so what are the attractors to moving into a private agency for an RN? I mean it gives that flexibility, that ability to pick and choose and not get tied into a shit show, so to speak. If they don't like a certain place, they can move on right. I think any initiatives should be into broad recruitment and retention. But it also needs to have in addition to those retention strategies, be broadening our ideas from what the traditional employment model offers."* (Employer participant who uses agencies)

> *"And then some of these provinces and territories, maybe if they need this sort of workforce, they need to build it so that they've got individuals that live in their communities that can be travel nurses. So that they understand the culture of the province or territory that they're in and that over time they have relationships with these communities. Maybe you've got your own travel team, and a nurse may go in and out of a community but maybe they go in and out of it two, three times a year. And so, while they may not be there the whole time, they still establish a relationship with a community and the community knows them and the community trusts them. It's very different. And then obviously, the money is staying in the community or at least in the province."* (Nurse leader participant)

2. Become an employer of choice

Participants discussed how public facilities should work on becoming an 'employer of choice' with a focus on providing nurses in the public system more flexibility, inspired leadership, enhanced professional development opportunities, and acknowledgement of their value. Below are quotes from the participants to expand on this.

> *"To ensure that you will make change in the work environment in order to bring back nurses who left the health care system. You need to become, as I said earlier, an employer of choice. If you are not able to be competitive with these private agencies, you won't be able to bring back them, and you won't be able to stop the bleeding inside your organization."* (Nurse leader participant)

> *"… where I want things to go is to improve retention in the public sector and improve the return of nurses who may have left the public sector for private travel agency opportunities. And let's bring them back. Let's find those opportunities for flexibility, for variety, for professional development, for inspired leadership, for all those things that will actually bring them back."* (Nurse leader participant)

> *"I think the toolkit that the federal government released is a very good piece of work that I think has some good tools in it that can help employers. I think that these strategies and these ideas are only good if there's a willingness to actually implement them and invest in them. And I see some organizations doing it and I see others not. And one of the things that I see is organizations and governments continuing to do what they've always done and that is jumping to the easiest solution. And they all think it's recruiting internationally educated nurses from countries that can't afford to lose them."* (Nurse leader participant)

3. A listening campaign with frontline nurses

Most participants discussed the importance of not only hearing from frontline nurses about what is needed in the current crises but acting on their suggested solutions. Below are quotes from the participants to expand on this.

> *"How do we involve frontline nurses to be part of identifying how we don't need to have agency staff. You know, they need to also provide us with some of those answers and so I think we need like almost a listening campaign… to understand. So how is agency, what works with agency, what doesn't work with agency, how can we get past that, what do you need in order to be successful."* (Employer participant who does not use agencies)

> *"I think the key is to have open and honest communication with government officials, and employers, and nurses on the ground and ask them their ideas. "What will it take to get you to come back to [province], to leave an agency and come back to us, or to actually graduate and stay here and take a permanent position?"* (Nurse leader participant)

> *"There needs to be a really concentrated focus on how do we deal with the work environments that are creating these situations that are driving nurses away from their jobs. And that means you need to bring them to the table. They need to be heard and there needs to be – nurses need to be*

participating in what are the solutions that are going to get us through these situations. And the things that they need to be implemented. And resources need to be provided. If the government and these hospitals and health authorities can spend millions and millions of dollars on agencies, they can spend some of those millions of dollars to make the workplaces safer, make them more palatable… if we'd have place-put those millions and millions of dollars into retention initiatives that we have been recommending to the government. It wouldn't even cost that much. We probably wouldn't have had all of them leave the system and we probably would be able to recruit because our vacancy would not be as bad as it is. And I think that the systems would have been more stable." (Nurse leader participant)

"I don't feel that this is beyond repair… many are leaving again because of the practice environment. So, what we do have the ability to work on that as well, and that you'll be seeing that ratios will be coming to the table. [Nurses] are loud and clear about ratios. They not only want fair wages, they want to be able to provide the very best care that they can." (Nurse leader participant)

4. Graduate more nurses from the education system

Participants discussed the need to not only increase the number of students graduating from the nursing education programs, but to increase the resources in this system to match the number of students enrolled while promoting of the retention of students in the programs. Below is a quote from a participant to expand on this.

"… we need to increase our throughput or our class size of nurses and whether RNs or PNs and health professionals. So, we need to increase it, and how we're going to do that is the challenge, and we need to look at the curriculum. I think it's time to look at, I mean, yes, baccalaureate for an RN, and I think that that's something that we shouldn't compromise on, but looking at the curriculum, that they are more prepared to practice, because there's….not the same level of resources and knowledge in the system that there were 20 years ago because it's destabilized." (Employer participant who uses agencies)

5. Mentorship programs

Participants discussed the importance of developing new or bringing back previous mentorship programs, such as the one in Saskatchewan (Government of Saskatchewan, 2008) which was in partnership with the previous government. Below are quotes from the participants to expand on this.

"… get nurses through, but then on the other side, whether it's in acute care or wherever you're consolidating or you're learning, we need to support those nurses that are those mentors, those educators, those resources to the newer nurses to practice." "Because the thing is that if you don't set – if they're not set up for success within practice, you lose them. You only got the first one to three years. And then you lose them." "And it's very tough to do. Whether you've got 20 nurses in your organization, or 2,000 or 3,000. And then to retain them, it's preceptor programs, mentorship programs for the point of care nurses, because they're the ones that are delivering the patient care. And it demonstrates that we value them." (Employer participant who uses agencies)

> *"… we need to stand up a mentorship program. One that actually has human and financial resources attached to it, that there's meaningful work to be done, there's meaningful connections to be made, so that these young graduates… actually have people that they can rely on in the workplace that are going to help them through, going to help them understand, going to give them their legs, so to speak, to stand on."* (Nurse leader participant)

> *"… there needs to be some investment in transitioning new people into systems. We need to better support new graduates and internationally educated nurses so that they're successful. And that means investing and one of the things that I frequently get told when I go out and speak with nurses is it is uncommon now to go onto a nursing unit in a hospital and see the team of nurses where there's someone that's got more than five years of experience on it."* (Nurse leader participant)

6. Teach rural nursing as a specialty

Participants discussed the significant challenges experienced by rural and remote areas in recruiting and retaining nurses. One recommendation was having a clear initiative focused on retaining rural and remote staff and investing in rural and remote nursing as a specialty with increased intention to bring students and nurses to this area. Below is a quote from a participant to expand on this.

> *"… in terms of a clear initiative around retaining rural staff or staff in rural centers, without having to have such a high reliance of agency, is to really invest in the value of rural as a specialty and what does that look like? And how do we support? And how do we layer supports at a rural site."* (Employer participant who uses agencies)

7. Use return-service agreements for remote/rural areas

Another recommendation for rural and remote areas was using or increasing the use of return of service agreements to help reduce the administrative workload with centralized tracking and more equitable distribution. Below is a quote from a participant to expand on this.

> *"There are rural incentives like return of service agreements that sites like ours have access to. Those initiatives have been in place, though it hasn't necessarily made a huge dent in our vacancy rates. One of the things I will say that's starting to ease that pressure somewhat, I think about the distribution of agency resource is more… a central team that's reviewing agency contracts. Like they're managing more. It's not completely transitioned over to this, but it's heading there. Where the interface with the private agencies will be more handled centrally rather than site by site. So, I think that that's overall, an improvement, so that there could be more centralized tracking and more equitable distribution, or perhaps some degree of strategy to balance site staffing levels across the system."* (Employer participant who uses agencies)

8. Shift models of care to value nurses' essential work

Participants discussed the importance of shifting models of care to promote interprofessional collaboration and clinical models that value the essential work nurses do. Below are quotes from participants to expand on this.

> *"… we're very focused on RN. And now [LPN] as well. But I think another factor that driving it and that may not change until we can shift into a place of a stronger sense of interprofessional collaboration, looking at different roles that can do different things, pushing the scopes on different areas of practice, including for nurses too. But being a little more creative and open-minded to how we staff and looking at different ways of collaborating that means."* (Employer participant who uses agencies)

> *"And I think we need a shift in our models of care, but we also need a shift in terms of how we're valuing the essential work that nurses do." "And I think there's a gendered component we can't ignore, like the nursing profession is over 90 percent feminized, female. And so, this is also about the way in which we value the work and labour of women in society writ large."* (Nurse leader participant)

9. Think from a universal health care perspective

The importance of maintaining a not-for-profit health care system was emphasized by several participants. They noted that for every public dollar that goes to an agency, one is removed from the public system. Below is a quote from a participant to expand on this.

"I think it's a hard balance between making sure that we are meeting our mandate as a hospital to ensure that we're providing high quality and access to care. And that monetary piece, I struggle… it is a challenge I think for many of us to think that hard-earned tax dollars are going to an agency where they're making a profit. Because every dollar that leaves the public health care system for a profit for them means that we are not going to be able to provide something at our hospital, whether we're going to have to reduce services or change the staffing levels or changing the staffing mix, using non-professional providers because it's going to be cheaper. I think we have to figure out how to do this right because those health care dollars need to be embedded in providing patient care not…for a profit." (Employer participant who does not use agencies)

18. Where should the nursing profession go from here?

In the interviews with nurse leaders, participants were asked where they thought the nursing profession should go from here, based on their role and experiences. While many ideas were discussed, most were included in the previous section asking about what must to be done to reduce the use of agencies. Those specific to the nursing profession are discussed here.

1. Change how we think about the nursing workforce

Participants discussed how the expectations of the nursing workforce have changed, and how the nursing profession must 'change with the times'. Participants discussed the need to 'dust off' collective agreements to see where there are opportunities for flexibility and find new ways to incentivize nurses. One example would be the creation of interfacility agreements to provide nurses with opportunities to move between facilities. Below are quotes from participants to expand on these ideas.

> *"… empower our workforce and realize that just because something worked 20 years ago, doesn't mean it is going to work now. We need to change with the times. Certainly, the Union, certainly employers, and I think we'd be much better off from an HHR perspective, from a quality of patient care, if we modernized all of this together and develop this workforce that is truly empowered to provide the best care. And empowered and proud again of our profession… We are very much deserving of a safe, sustainable, healthy work environment. And by offering that and changing scheduling, changing wages, changing compensation broadly, benefits. We will provide the best care because a happy and healthy workforce does provide the best care."* (Nurse leader participant)

> *"I think it does require a strategic reorientation…I've heard examples of students who have graduated the very top of their class, they're plugged into a full-time line. And then they several months later say, "I was the top of my class and now I've now gotten into a master's program that I want to do part time. So can I take one day off a week?" "No, you don't have seniority."* (Nurse leader participant)

> *"… I think until there's a different alternative from an agency, we're going to have to use them, or we have to figure out a different way to get people into the rural areas. We have to have different enticements to support that. And that might involve working with the unions to see, you know, can we have interfacility agreements, can we look to see how we can do things differently. I think agency staff will be needed until we can navigate that."* (Employer participant who does not use agencies)

> *"It's not a one-size-fits-all approach. I think we are always so concerned about equity, which is super, super important. But I think we need to allow for flexibility within existing models as well… equity needs to be centred, of course, in all that we're doing. But it's just I think we are so seized with equitable scheduling and need to sort of dust off collective agreements to sort of see where are the opportunities for flexibility that currently exists? And I'm not saying rewrite them all and renegotiate them all, because I think the collective agreements are very good. But I think we tend to veer towards the easiest staffing model, which doesn't work in today's environment."* (Nurse leader participant)

2. Nursing task force and health human resource strategy

Participants discussed the immediate need to create a nursing task force and a coordinated strategy at provincial, territorial and federal levels. A concern was raised by one participant that 'nurses are losing their influence in Canada due to fragmentation' and it is time to bring everyone together at one table to strategize and think outside of the box while developing a national plan to 'wean off agencies'. Below are quotes from participants to expand on these ideas.

> *"All nursing has to be at one table. We're in a nursing – this is not a health care crisis this is a nursing crisis. We're in a nursing crisis in this country… And we need all the stakeholders at the table, because we all need to strategize and think outside the box." "There has to be a plan to wean ourselves off these private agencies, the reliance on these private agencies. And our vision is that we increase the seats at Schools of Nursing, we address violence in the workplace, meet people where they are when it comes to flexibility, the childcare needs, a lot of stuff that we're working on."* (Nurse leader participant)

> *"… changes must happen if we're going to find our way out of this, and the biggest change that has to happen is that they have to sit down and have crucial conversations with [nurses] on the front lines, that's what has to happen. We need to get a nursing task force stood up, we need to immediately begin having conversations asking people, "Why have you left? What can we do to bring you back?" We need to incentivize to stabilise, there's no two ways about it, and have those conversations, promise people, "We will give you this amount of money, but we need you to stay for at minimum a year to stabilise what we're doing." "… we're spending gobs of money to keep the agency nurses going, and rather than make the proper investments to stabilise, we just continue to destabilise the system. So, I think to bring it back around to the original question is, it's as simple as forming a taskforce and having the conversations and getting some of these ideas up and going, they've done it before and we could certainly do it again, the money is there, that's obvious, we're spending it hand over fist in the wrong direction, we need to course correct, and be paying attention to what needs to happen and paying attention to the nurses who do the job."* (Nurse leader participant)

> *"… there needs to be… a federal health human resource strategy. We have a* Canadian Health Act*. And federal government can say all they want; provinces are the ones who are responsible for that. But no, if you're given the money, you need to have a reciprocating – you tell me what you're going to do with that money, because it best be going to retention and recruitment in health care."* (Nurse leader participant)

Synthesis of findings

The overall purpose of this research study was to examine the high use of agencies across Canada. Various methods were used to collect data from several primary and secondary sources to provide multiple perspectives. The findings expand the data published in media articles during the past four years, and illustrates that this is a multilevel issue across the different groups of nurses who participated in this study. A synthesis of the findings is outlined below.

Available data on agency use

In total, 472 nursing/staffing agencies were identified with several agencies providing services within one province, others providing services across two or more provinces, and at least 11 agencies providing services through federal contracts. Three health authorities in Quebec reported using the highest number of agencies with one reporting a range of 249 to 262 followed by Manitoba with a range of 30 to 58 agencies used by health authorities. The practice areas where agencies were reported to be the most frequently used were LTC homes, critical care units, EDs, rural and remote settings, and outposts/nursing stations.

Data regarding agency use were more easily obtained in some jurisdictions than others, therefore the results presented in this report only reflect the data that was available. The available data that were obtained demonstrated the exponential rise in the costs and total number of agency hours used by health care facilities between 2020-2021 and 2023-2024: 1) there was a 6-fold increase from $247.9M to an estimated $1.5B, with an additional $3.2B in federal contracts between 2019 and 2024; 2) the average hourly costs paid by 18 health authorities and hospitals to agencies increased by 34% from $99.6/hr to $133.8/hr; and, 3) there was a 3.4-fold increase in the total number of agency hours used from 2.1M total hours to 7.3M total hours for RNs and LPNs, which is equivalent to 3,724 FTEs. Initially, three times more hours for RNs were required compared to LPNs, however this gap has closed as the need for LPN hours has increased almost 4-fold compared to the increase of 2.9-fold for RN hours. If looking back even further, the rising use of agencies is evident in some jurisdictions prior to COVID-10. For example, in British Columbia, data provided by the British Columbia Nurses' Union showed a 24-fold increase from just under 23,000 agency hours in 2016-2017 to over 550,000 hours in 2023-2024.

The data obtained further reflected the large variation in hourly agency rates charged to health care facilities and wages paid to nurses working with agencies. Based on data collected from health care facilities and media reports, the lowest reported RN rate charged by agencies was $65/hr in Manitoba and the highest rate was $312.4/hr in Newfoundland and Labrador. The largest range of rates charged by agencies were in Ontario hospitals for both General RNs ($53.5 to $260/hr) and Specialty RNs ($81.2 to $195/hr). In the surveys completed by RNs working with agencies, a wide range of hourly wages ($39 to $300) paid by agencies to nurses were similar to the ranges reported by health care facilities, however, the bottom range for wages ($39) was much lower than the lowest reported hourly rate charged by an agency of $65/hr in Manitoba. Survey participants also reported differences in hourly wages ranging from $2 to $74 between not only agencies but also provinces, locations within provinces,

and specialty practices. Participants stated that wages paid in British Columbia were in the $55 to $62 range, New Brunswick in the $90 to $110 range and Ontario in the $70 to $100 range depending on the agency. Other participants stated it was $60 to $70 in LTC homes, and $90 to $120 for ED. Similar differences were found for LPNs, RPNs and NPs.

Determining and comparing actual agency rates and hourly rates remains an enigma, as the rates are not only dependent on the base hourly rate, but also which direct costs are included. The most frequently reported direct costs paid by health care facilities included costs related to travel, accommodations, and per diems. Onboarding was the most frequently reported indirect cost with orientation, identification badges, employee health, scheduling, etc. However, there was variation on what was included by each agency and who (agency, health care facility, individual nurse) paid for which cost. One hospital reported "we have one (agency) that charges a 35% service fee. And two others that charge daily per diems ranging from $40 to $60 per day." Others reported that an agency charged a 25% service fee or $120/day for accommodation. This illustrates not only the variation in hourly agency rates or wages but also the complexity of determining the factors that contribute to agency costs.

Pre-graduate nursing students

The majority of student participants reported that they had not been recruited by an agency, however those who had been recruited indicated that LinkedIn, email, text, and recruitment fairs were the common recruitment approaches. Most reported they would consider working for agencies right after graduation. They would work for both an agency and a public facility with the agency work being a part-time second job so they would have control over their work environment, gain experience, and receive benefits. The characteristics that were most important to them when looking for a nursing job after graduation were transition programs, mentorship, and location, followed by the work environment (supportive, team morale) and salary/wage. When asked if they had any concerns about support during their early practice as a new graduate, 35% were concerned about the lack of orientation, formal support or training and financial/work availability. When discussing how they thought their career would progress, participants discussed the failing health care system and "publicly funded roles [being] fraught as there is a lack of ability to give health care in a way that is sustainable" and the need to improve the system. As a long-term option, many participants preferred staying in the public health care system during their career but as one participant stated, "it all depends on the way I will be welcomed by the people of the institution."

Nurses working with agencies

Based on the data provided by CIHI's HWDB and CNO's Nursing Data Dashboard, the number of LPNs who reported working with an agency as a primary workplace rose from 3,359 in 2018 to 3,509 in 2022, while the number of RNs rose from 3,911 in 2018 to 4,028 in 2021. The two provinces with the highest numbers were Quebec and Ontario, and in a CNE survey, a health authority in Quebec reported 1,696 nurses working with agencies in their facilities during one fiscal year. However, the numbers reported by health care facilities do not align with the numbers in CIHI's HWDB as some health care facilities reported much higher

numbers of nurses from agencies than were identified in the HWDB for their jurisdiction. The data in the HWDB is based on standardized data submitted to CIHI by each nursing regulator which would reflect the number of nurses registered to practice in that jurisdiction, including those who work with agencies. This suggests that the data may not be reflective of the number of nurses who work with agencies, possibly due to how the questions are asked on the annual registration form. For example, nurses who work as an independent contractor (self-employed), may or may not identify an agency as their primary workplace, and nurses who report working with agencies as a secondary workplace also may not be included. In this study, more than 68% of nurses who work with agencies reported that they worked with both an agency and a public facility at the same time.

The most commonly reported reasons for working with agencies included better pay, work-life balance, control over schedule, more flexible hours, and better working conditions. The majority of survey participants reported that they had not been recruited by an agency, however those who had indicated that email, word of mouth from coworkers and friends, phone calls, texts and LinkedIn were the most common recruitment approaches. Over 60% of participants reported that they had been asked to recruit other nurses, and it was reported some agencies pay ‘referral money’ for this recruitment.

When working with agencies, most participants reported working in the public system prior to working with an agency, not resigning from their job in the public system, and working with both an agency and the public system simultaneously with hospital and LTC homes being the main type of facilities where they worked. The majority did not return to work in the same public facility as an agency nurse. Most participants’ work status with an agency was casual/contract based (select own hours to work or work on a contract basis with full-time hours). Among the participants who worked with an agency and public facility simultaneously, their work status with the public facility was predominantly permanent casual or permanent part-time. Close to 80% reported that they did not have the option of receiving benefits, and those who did receive benefits reported receiving dental, medical, sick time, all benefits except pension, and group/full benefits.

Most frequently nurses working with an agency would work a 12-hour day shift. Half of the survey responses reported that participants were normally in the same facility for one to three months or four weeks or less. This varied depending on the contract and facility’s needs, and for some participants they could choose how long they were in each facility. The majority did report that they were scheduled in the same practice areas consistently, however 30% also reported going to different areas or types of floors regularly. When starting to work at a new facility, the majority of participants’ responses reported receiving some type of corporate or unit orientation with varying lengths including education modules (online or in-person), shadow or buddy shifts with permanent nurses in the facilities, or computer training only. The length of orientation ranged from 20 minutes to 40 days, and close to 17% of the responses reported minimal or no orientation when starting at a new facility.

Participants reported that the main advantages of working with an agency were higher pay, opportunities to network, flexibility in choosing schedules, having new experiences, having different opportunities, and avoiding workplace politics and administrative burden. The main disadvantages they reported were uncertainty of where they were working, concerns

if putting their nursing license at risk, isolation, not having benefits, challenges with taxes (if independent contractor), and negative portrayal in the media. Participants were also asked how working with an agency impacted them personally and professionally in the areas of patient safety, teamwork, and continuity of care. Personally, most participants reported that working with an agency was positive with higher wages and work-life balance, but in some cases, it did change their relationships with colleagues and friends. Professionally, participants reported opportunities to 'push or test own limits' with: 1) improved skills in being a team player; 2) increased adaptability and flexibility travelling to different practice areas and teams; 3) increased knowledge, skill and judgement with more exposure to different ways of practicing; 4) professional growth and development with increased confidence and independence; 5) more experience working with people in various roles and developing better 'people skills'; 6) improved communication skills with others; and 7) increased focus on following policies, standards, best practices and understanding their scope of practice. Participants discussed that working with an agency had a positive impact on patient care as units had more staff to provide quality care, and by having more time off they felt they went to work feeling 'fresh'. They also reported that being placed in the same facility/unit for a longer time or assigned consistent patient/client assignments promoted continuity of care and level of comfort, but interview participants also identified how the short-term contracts and constant turnover of team members could negatively affect the care being provided over time.

Several participants reported a lack of support in facilities, feeling alone, being an outsider on the nursing team, feeling less assertive working in new places with difficult teamwork/communication due to the lack of familiarity, being treated differently, having to earn the team's trust by demonstrating their competence, and feeling pressure due to the wage discrepancy or perception of agencies. Participants identified that the role may not be appropriate for new graduates because of the importance of needing a strong understanding of their scope of practice to ensure they don't put themselves, their patients/clients/residents and their license at risk. They also outlined how nurses working with agencies may not always be placed in the best areas due to a lack of experience in that specialty or language barriers (e.g., English-speaking nurses being placed in French-speaking hospitals).

Managers and nurses working in health care facilities which use agencies

In general, nurses and managers participants reported an average of 3-5 nurses from agencies working each shift in their facility or unit, with a wide range of 0 to 100 reported. Those who reported 0 indicated that their facility or unit used agencies more in the past than currently or because of their specialty area they did not use agencies, but they were used elsewhere in the facility. The majority of participants reported working with nurses from agencies on a daily basis or 1-2 times per week with approximately an hour spent each shift training, directing or redirecting them. However, this amount of time ranged from 0 to 720 minutes (12-hour shift) for nurses and 0 to 240 minutes (4 hours) for managers. This illustrates that a significant amount of time was spent by both nurses and managers to orientate, answer questions and provide training to nurses working with agencies.

The majority of participants reported that they had not been recruited by an agency, however those who had reported that email, LinkedIn, text, and phone calls were the common recruitment approaches. When asked why they stayed in the public system, nurses and managers identified benefits (e.g., health, dental, pension), wanting to keep their seniority, the importance of community and morals/values when deciding between the public and private health care systems, valuing consistent teamwork, wanting to stay within a union, and wanting a stable environment.

When asked to identify the advantages of health care facilities using agencies, participants reported additional nursing staff helped to fill vacancies, improved nurse-to-patient ratios and decreased workload. In addition, nurses working with agencies were knowledgeable and shared experiences, were willing to pick-up last-minute vacancies or shifts, helped to decrease mandates for overtime, provided opportunities for vacation and time off, improved permanent nurses' mental health, and prevented closures or cancellation of services. Participants also identified disadvantages, including a strong sense of loss of unit values and culture as they were continuously working with new team members who did not understand 'who we are and how we work'. They also described the loss of a 'consistent team' where they no longer worked with familiar faces, people they knew and trusted, resulting in little camaraderie at work. The frustration with no, little or inadequate orientation being provided by the facility to nurses working with agencies was also a disadvantage.

In addition, participants were asked about the implications of using agencies on patient safety, teamwork, and continuity of care. Most participants identified that the impact varied depending on the experience of the nurses from agencies. The short contracts and constant turnover of team members impacted: 1) the team dynamics and workplace culture; 2) the workload of permanent nurses as they were expected to provide orientation for new team members, review protocols and ensure they were being followed, and complete additional tasks required for the overall unit function; 3) continuity of care due to lack of familiarity with patients/clients/residents, resources, policies, unit routines and protocols, charting requirements or scope of practice in facility; 4) LTC residents not being familiar with nurses leading to increased confusion and aggression; and, 5) the anticipation of long-term patient issues. Participants also reported that permanent nurses felt disrespected and devalued by their facility due to the wage disparity, lack of recognition for staying in the jobs, and having their shifts or hours continuously altered for the new team members. A small number of participants identified that the extra staff helped improve patient safety and continuity of care on their unit, reduced burnout of permanent nurses, and improved morale as more staff helped reduce the amount of overtime and mandates while providing opportunity for vacation or time off.

Health care facilities

Employers reported using agencies for several reasons, with the main reasons including: 1) being unable to fill vacancies, having difficulty recruiting and retaining nurses, needing to meet nurse-to-patient ratio regulations, and staff coverage for vacation/sick time. In rural and remote areas, staffing challenges were highlighted as more complex and pronounced than in urban facilities and with larger urban sites now relying more increasingly on agency staffing, it is drawing away from the rural sites even further; and 2) fulfilling service obligations and

remaining open was essential to their communities, however participants described the tension between trying to balance the fiscal responsibility with making sure they kept the doors open. Two studies in the scoping review also identified hospitals hiring "preferred agencies" temporarily instead of hiring permanent staff for perceived cost saving measures without impacting service delivery.

In the surveys completed by nurses and managers, participants also identified poor retention strategies by employers in retaining nurses as a contributor to the workforce shortages and ultimately the use of agencies. This was also discussed during the interviews with nurse leaders and employers when asked why the use of agencies has increased so dramatically in the last year. Participants discussed several factors including employers not listening to the voices of nurses, not creating healthy and safe workplaces, underestimating the number of nurses leaving due to toxic workplaces, and demographic shifts in the nursing workforce with younger generations wanting to work differently with more flexibility.

In the interviews with employers who have never used agencies, participants discussed their reasons for not using agencies. In listening to other employers, they had heard about the challenges of working with agencies, including the impact on staff morale when nurses work alongside other nurses making significantly more money in the same role and not always receiving the skillset they requested or paid for when working with agencies. Other reasons included: 1) having a strong belief in the public system; 2) the financial impact on the facility if money spent on agencies versus paying nurses in their facility overtime; and 3) determining that it would be hard to 'come back' from relying on agencies to fill staffing needs.

When asked about the impact of agencies in health care facilities, employers who used agencies described: 1) the 'destabilizing effect' or 'erosion of relationships' that the lack of continuity within a team has on the morale of the team in terms of not having that base knowledge or strong relationships that an experienced team can develop together; 2) the extra workload for permanent nurses due to the constant turnover with new team members. This extra workload was described as falling 'under the general umbrella of what we do in a day' with continuous orientation, answering questions, ensuring protocols are followed, and how this introduces 'resentment and certainly challenges'; 3) a significant burden on management with scheduling, contracts, managing travel and accommodations including lease agreements. This resulted in new positions being created to manage the agency turnover and additional workload for clinical nurse educators; and, 4) a vulnerability in the system due to a facility not having the same degree of ability to maintain quality management by overseeing or following up directly with a nurse from an agency when a clinical practice concern is raised. While they can address concerns with the agency, they are reliant on the private agency to follow-up but there is a lack of clarity in the agency's process in this area. Participants also discussed having less influence over nurses working with agencies with learning and development, and concerns over the quality of care specific to the lack of familiarity with the system, environment and teams.

Nursing leaders

Nursing leaders also discussed the negative impact on nurses' morale when working alongside other nurses making more money including having their travel and accommodations covered and receiving preferential schedules, assignments and education. When discussing patient safety, participants discussed the negative impact with facilities restricting or limiting access to certain technology (e.g., Omnicell and Pyxis machines) affecting medication administration and documentation systems (e.g., Epic and Cerner) delaying documentation as nurses working with agencies either resort to manual/paper or other colleagues completing the documentation for them. If other health care team members are unable to access documentation or if the documentation is not up-to-date, this can lead to patient safety and care issues. When discussing the impact on continuity of care, nurse leaders discussed how all nurses strive to provide quality care but due to the transient nature of agency contracts, continuity of care is challenging. They linked this closely with teamwork and the relational aspects of care such as understanding the nuances of other health care providers, knowing who to call in an emergency, who you can rely on, as well as knowing policies, expectations of the facility, the patient/client/resident population, and the community context. Without having these relationships, the risk is that agencies are 'just filling holes in the system' and providing patient care is 'not as simple as that'. The sxtra work then falls back on the permanent nurses to ensure the expectations are met. In addition, in some provinces, nurses working with agencies have their scope of practice limited by the facility which is an additional challenge for the team. One participant also discussed the lack of stability in the nursing workforce with the loss of experienced nurses who would mentor and support the professional socialization of new nurses, and how this is a detriment to patients/clients/residents.

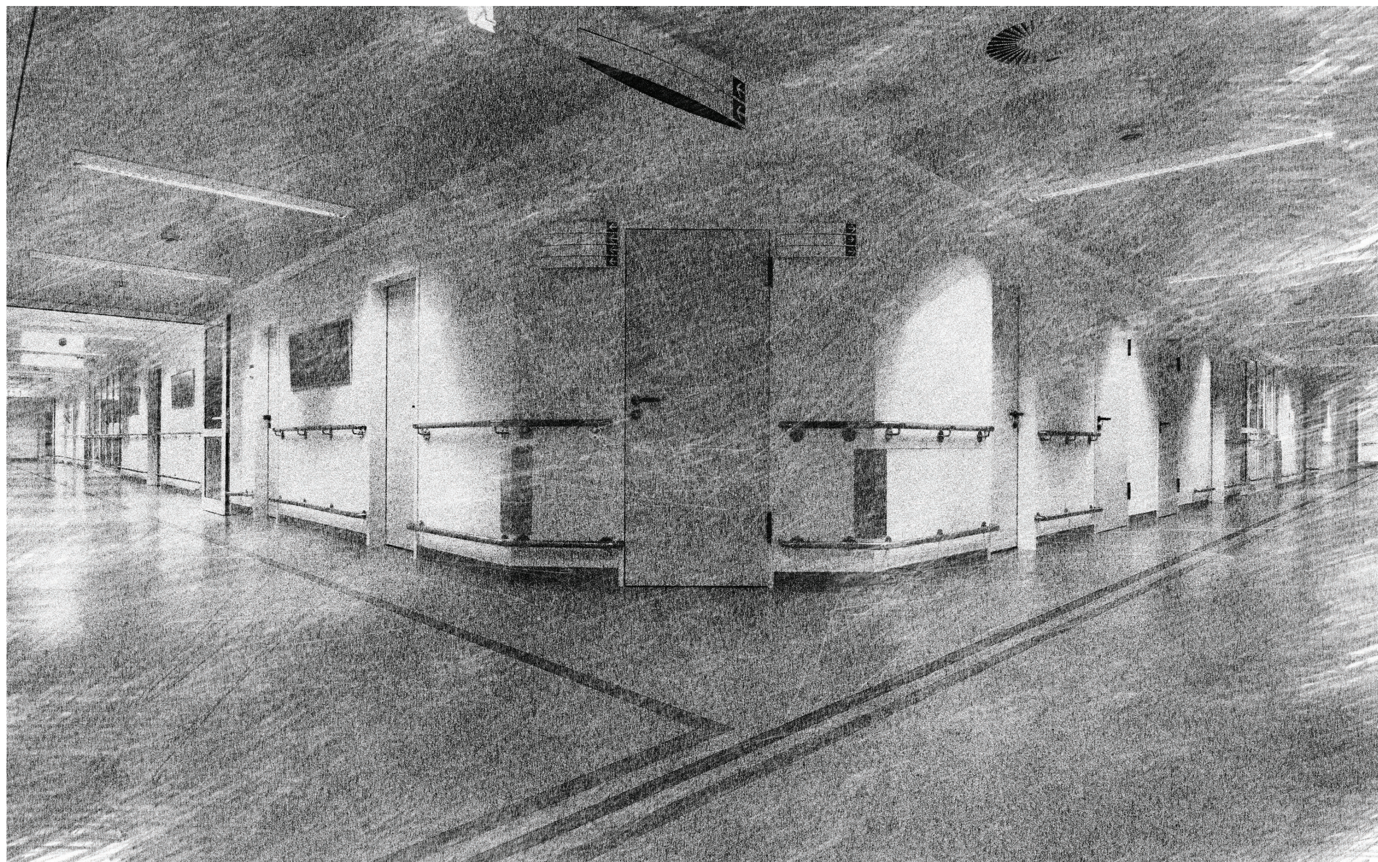
Nurse leaders were also asked how, in their roles, they have seen the use of agencies impact the public health care system. Participants discussed the: 1) disruption of the public system with the exploitation of public health care monies. Agencies have taken advantage of the current situation and are 'gouging the public system' with pay discrepancies that the public system cannot compete with, forcing some facilities to take out loans to sustain staffing levels, and creating further challenges for rural and remote areas to recruit nurses; 2) lack of transparency, oversight and accountability. Recent media attention illustrates the lack of transparency, oversight and accountability by facilities and governments to agency contracts and overspending. Discussion included how some agency contracts have clauses that prevent nurses from staying and working in a province's public health care system, for 6-24 months after leaving an agency; 3) impact on rural and remote areas. The original intent of agencies was in supporting remote/rural areas where recruitment and retention of nurses remains a challenge. The increased use of agencies in urban centres has made it more difficult for rural and remote facilities to recruit due to competition and limited funds; 4) negative portrayal of nurses working with agencies. Concerns were discussed about nurses being 'blamed' in the media for the rising use of agencies when structural systemic issues are the root of the problem and need to be changed; 5) eroding public confidence in the nursing profession and public system. The negative publicity is eroding the public confidence in the nursing profession with the notion that nurses are 'just plugging holes' in the system instead of elevating the profession to being valued health care providers. It has also impacted the confidence that the public has in the public system; 6) destabilization of the nursing workforce. The use of

agencies and nurses leaving the public system has destabilized the nursing workforce as we are relying on nurses 'dropping in and dropping out'. While we have more nurses than ever in Canada, many are leaving the profession and/or leaving the public system because the conditions are just unsustainable.

What more must be done to reduce the use of agencies?

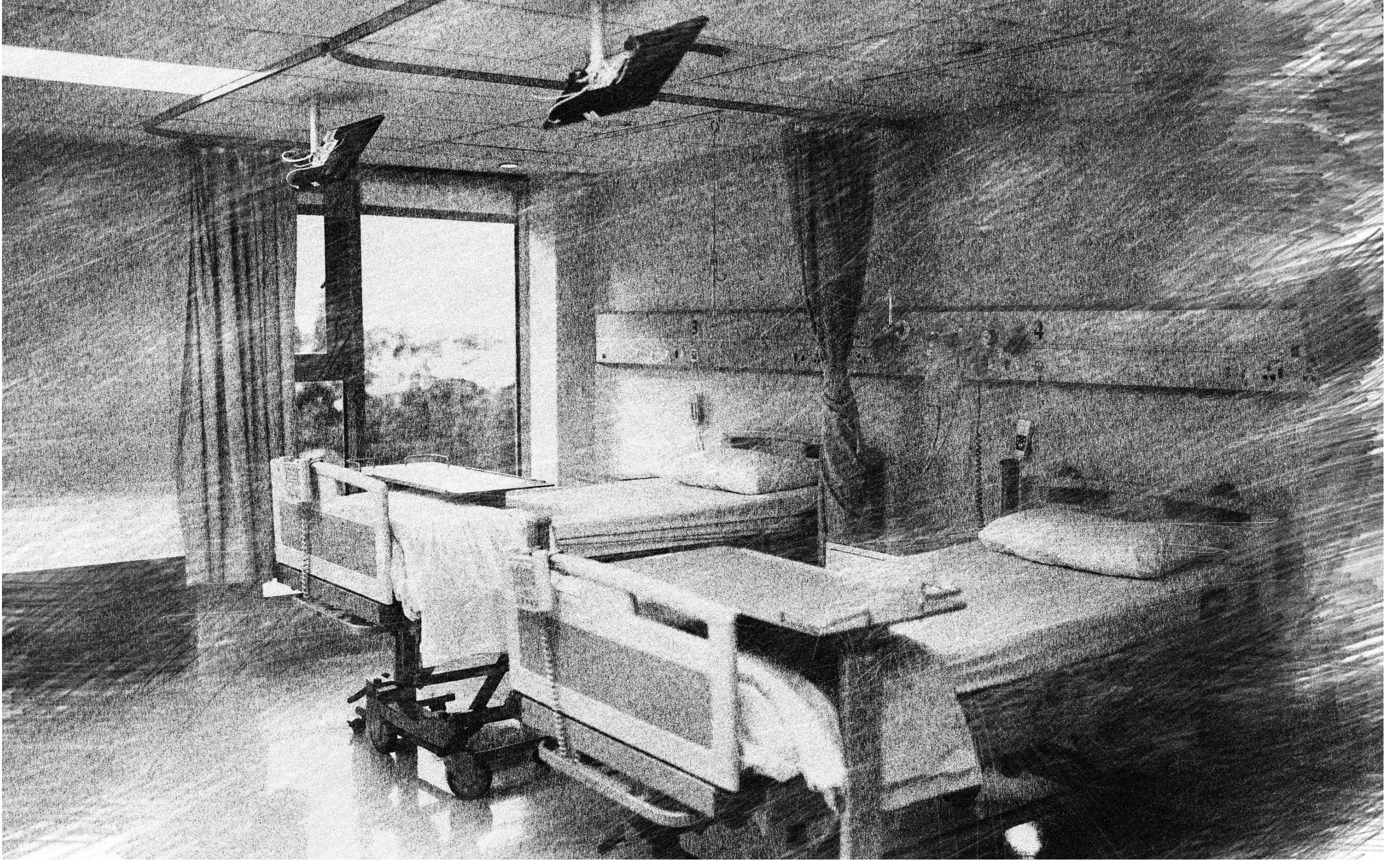
In the surveys with nurses who work with agencies, 13% reported that no strategies or initiatives would influence their return to the public system. However, other participants identified key strategies or initiatives that might influence nurses' return to the public system, including: 1) financial incentives, with better compensation, new or increased premiums as well as incentives such as extra pay for working in specialty areas, signing bonuses, free parking or coffee or reduction in the annual registration fees; 2) improved work conditions with better staffing, standardized nurse-to-patient ratios, no mandated overtime, safe work environments with zero tolerance for violence and better support from human resources for eliminating toxic behaviours; 3) flexibility in scheduling, benefit packages, vacation time, and job opportunities; and 4) recognition for expertise and appreciation programs. Retention initiatives could also include many of these strategies/initiatives.

Employers and nursing leaders were also asked to identify what more must be done to reduce the use of agencies. Their key recommendations included: 1) developing publicly funded, government-run centralized staffing agencies, similar to models currently in place in Manitoba, British Columbia and Newfoundland and Labrador. This includes staffing northern communities under a public funded model; 2) public facilities striving to become an 'employer of choice' with a focus on healthy and safe workplaces with inspired leadership, where nurses are offered more flexibility, enhanced professional development opportunities, and their value is acknowledged. The *Nursing Retention Toolkit* released by Health Canada (Government of Canada, 2024b) was strongly recommended by several participants with evidence-informed strategies for promoting the retention of nurses; 3) hosting listening campaigns with frontline nurses to not only hear about their ideas and what is needed in the current crises but acting on their suggested solutions. This includes a concentrated focus on dealing with the work environments that are driving nurses away from their jobs; 4) graduating more nurses from the education system and increasing the resources in this system to match the number of students enrolled while promoting the retention of students in the programs; 5) developing new or bringing back previous mentorship programs, such as the one in Saskatchewan (Government of Saskatchewan, 2008) which was in partnership with the previous government; 6) investing in rural and remote nursing as a specialty with increased intention to bring students and nurses to this area. Also increasing the use of return of service agreements in rural and remote areas to help reduce the administrative workload; 7) shifting to models of care that value the essential work of nurses; and 8) maintaining a not-for-profit health care system where private companies are not profiting by providing care to patients/clients/residents.



Where should the nursing profession go from here?

In the interviews with nurse leaders, participants discussed many ideas on moving forward with most discussed in the previous section. Those specific to the nursing profession included: 1) the immediate need to create a nursing task force and a coordinated health human resource strategy at multiple levels to bring everyone together at one table to strategize and think outside of the box while developing a national plan to 'wean off agencies". It is also imperative that the strategy include recruitment and retention into the rural and remote areas; and 2) changing how we think about the nursing workforce as their expectations have changed. It is time for the profession, employers and unions to change the approach to health human resource planning to empower the workforce and realize it is not a one-size-fits-all approach. This includes having crucial conversations with nurses on the frontline then re-evaluating collective agreements to create opportunities for flexibility and ways to incentivize nurses.



Conclusion

This report describes the current landscape on the use of agencies in Canada from multiple perspectives. While this report focused on the past four years, it is clear that the use of and the costs associated with agencies was rising well before the pandemic, then ballooned during the peak years of the pandemic, and continues to be a growing issue. This is not surprising as nursing shortages and deteriorating working conditions predate the pandemic, then a tsunami took place across the country with many nurses deciding that they have had enough and chose to retire early, leave the profession or leave the public system. Nurses have made it clear that they are working with agencies because of better pay, work-life balance, control over their schedules, more flexible hours and better working conditions. They want to be respected and valued. Nurses have been saying this for decades without enough action being taken. Agencies have finally provided nurses with an alternative to staying in toxic workplaces, and many agencies are taking advantage of this, and many governments are letting them. The costs associated with agencies continue to rise exponentially each year, which is in part due to the rising number of nursing hours required, but also due to rising rates being charged by agencies. British Columbia and Manitoba have attempted to regulate these costs, but many other governments have let the agencies set their rates with no obvious transparency, oversight or accountability to the public.

The use of agencies can be advantageous as the additional staff help fill vacancies, prevent closures or cancellation of services, allow vacations and improve the nurse-to-patient ratio.

However, due to the transient nature of agency contracts, there is a destabilizing effect on health care teams and unit cultures in terms of not having the base knowledge, trust and strong relationships of an experienced team. Not only does workload for permanent nurses increase, but there is also a significant burden on management with scheduling, developing contracts, and managing travel and accommodations, including lease agreements and cleaning contracts. Continuity of care is also impacted as frequent turnover impacts the understanding of policies, expectations of the facility, the patient/client/resident population, and the community context. Lastly, the lack of transparency in how agencies function also creates a vulnerability for health care facilities as employers do not have the same oversight or management of clinical practice concerns.

This is disrupting the public system with pay discrepancies that cannot be met by the public system. With larger urban sites now relying more increasingly on agency staffing, rural and remote settings are having even more challenges with recruiting nurses due to competition and limited funds to provide incentives. Permanent nurses are feeling disrespected and devalued when working alongside other nurses making more money with their travel and accommodations covered while receiving preferential schedules and assignments. Nurses working for agencies are being blamed or 'demonized' for the rising use of agencies instead of the structural systemic issues being discussed and changed. The negative publicity is further eroding the public confidence in the nursing profession overall with the notion that nurses are 'just plugging holes' in the system instead of elevating the profession to being valued health care providers. This has destabilized the nursing workforce at a critical time with many leaving or close to leaving the profession and/or the public system. There need to be crucial conversations that bring everyone together at one table to strategize and think outside of the box to empower the nursing workforce and develop a multi-layered national plan to wean off agencies. As the largest health care profession, nurses are often referred to as the 'canary in the coal mine' for how well the health care system is functioning. If this is true, what does our future hold for health care in Canada if we don't immediately address the structural systemic issues in the public health care system? Our health care system and the nursing profession cannot continue down this road, because the system is just not sustainable.

References

Adamski, T. (2024, May 23). Manitoba PCs accuse NDP of 'bullying tactic' in effort to draw private agency nurses back to public sector. *CBC News*. https://www.cbc.ca/news/Canada/manitoba/manitoba-nurses-union-tentative-agreement-1.7213163

AdvantAge Ontario. (2022, December). *AdvantAge Ontario survey on temp agency staff*. Unpublished presentation slides.

AdvantAge Ontario. (2023, November). *AdvantAge Ontario LTC staffing agency usage 2021 to 2023.* Unpublished presentation slides.

Alberta Health Services. (2022). *AHS contracts.* https://www.albertahealthservices.ca/about/Page12829.aspx

Alberta Health Services. (2024). *Travel nurse (North Zone Locum)*. https://www.albertahealthservices.ca/careers/Page12852.aspx

Alvarez, M. R., Kerr Jr, B. J., Burtner, J., Ledlow, G., & Fulton, L. V. (2011). Use of outsourced nurses in long-term acute care hospitals: outcomes and leadership preferences. *JONA: The Journal of Nursing Administration*, 41(2), 90–96.

Arksey, H. & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, 8,19–32.

Auditor General of New Brunswick. (2024). Report of the Auditor General of New Brunswick Volume I Performance Audit. https://www.agnb-vgnb.ca/content/dam/agnb-vgnb/pdf/Reports-Rapports/2024V1/Agrepe.pdf?random=1717507778207

Authier, P. (2023, February 15). Quebec aims to phase out use of private health-care agencies by 2026. *Montreal Gazette*. https://montrealgazette.com/news/quebec/quebec-tables-bill-limiting-use-of-private-health-care-agency-labour

Bae, S-H., Mark, B., & Fried, B. (2010). Use of temporary nurses and nurse and patient safety outcomes in acute care hospital units. *Healthcare Management Review,* (*October-December*), 333-344.

Barter, M. (2024a). *PHSA spent over $1.1 million on agency nurses from September 2023 to March 2024.* https://mattbarter.ca/2024/05/09/phsa-spent-over-1-1-million-on-agency-nurses-from-september-2023-to-march-2024/

Barter, M. (2024b). *VitaliteNB spent over $68 million on agency nurses from September 2023 to March 2024.* https://mattbarter.ca/2024/05/14/vitalitenb-spent-over-68-million-on-agency-nurses-from-september-2023-to-march-2024/

Barter, M. (2024c). *NL Health Services spent over $40 million on agency nurses from September to December 2023.* https://mattbarter.ca/2024/03/20/nl-health-services-spent-over-40-million-on-agency-nurses-from-september-to-december-2023/

Bellerose, D. (2024, April 7). Imposition de tarifs uniques aux agences privées en santé: finies, les infirmières à 150$ de l'heure. *Le Journal de Québec*. https://www.journaldequebec.com/2024/04/07/imposition-de-tarifs-uniques-aux-agences-privees-en-sante--finies-les-infirmieres-a-150-de-lheure

Ben-Ahmed, H. E., & Bourgeault, I. L. (2022). *Sustaining nursing in Canada: A set of coordinated evidence-based solutions targeted to support the nursing workforce now and into the future*. https://nursesunions.ca/wp-content/uploads/2022/11/CHWN-CFNU-Report_-Sustaining-Nursing-in-Canada2022_web.pdf

Benson, A. (2012). Labor market trends among registered nurses: 2008-2011. *Policy, Politics, & Nursing Practice*, 13(4), 205-213.

Brazier, J. F., Geng, F., Meehan, A., White, E. M., McGarry, B. E., Shield, R. R., Grabowski, D. C., Rahman, M., Santostefano, C., & Gadbois, E. A. (2023). Examination of staffing shortages at US nursing homes during the COVID-19 pandemic. *JAMA Network Open*, 6(7), e2325993.

Callan, I. & D'Mello, C. (2023, January 9). Ford government documents admit low wages, Bill 124 worsening health staffing issues. *Global News*. https://globalnews.ca/news/9340310/health-care-ontario-bill-124-ford-government-documents/

Canadian Federation of Nurses Unions. (2024). *CFNU Member Survey Report.* https://assets-global.website-files.com/64108fa6cd96c24e82418a19/65f2170954d430c73820ef18_2024%20CFNU%20Members%20Survey%20-%20Web.pdf

Canadian Institute for Health Information. (2022). *Health Workforce in Canada, 2021– Quick Stats (XLSX)*. https://www.cihi.ca/sites/default/files/document/health-workforce-quickstats-2021-data-tables-en.xlsx

Canadian Institute for Health Information. (2023a). *Hospital staffing and hospital harm trends throughout the pandemic.* https://www.cihi.ca/en/hospital-staffing-and-hospital-harm-trends-throughout-the-pandemic#ref6

Canadian Institute for Health Information. (2023b) *Nursing in Canada, 2022 — Methodology Notes*. https://www.cihi.ca/sites/default/files/document/nursing-in-Canada-2022-meth-notes-en.pdf

Canadian Union of Public Employees, Local 2119 v Perth and Smiths Falls District Hospital, 2024 CanLII 42121 (ON LA), <https://canlii.ca/t/k4kw9>, retrieved on 2024-08-21

Carroll, L. (2024, February 26). N.W.T. spent $5.2M last year on agency nurses, who are paid more than local nurses. *CBC News*. https://www.cbc.ca/news/Canada/north/n-w-t-agency-nurses-higher-pay-local-nurses-1.7122459

Casey, L. (2023, March 1). Ontario reviewing nursing agency practices in long-term care homes, minister says. *Toronto Star.* https://www.thestar.com/news/gta/ontario-reviewing-nursing-agency-practices-in-long-term-care-homes-minister-says/article_e49312c9-6339-5726-9794-751382c8227f.html

Castle, N. G. (2009). Use of agency staff in nursing homes. *Research in Gerontological Nursing*, 2(3), 192–201. https://doi.org/10.3928/19404921-20090428-01

CBC News. (2024, May 16). Manitoba taking steps to increase oversight of private nursing agencies, premier says. *CBC News*. https://www.cbc.ca/news/Canada/manitoba/nurse-agencies-rfp-1.7206842

CBC News. (2023, February 22). Use of private agency nurses of Vitalite spiked in 2022, documents reveal. *CBC News*. https://www.cbc.ca/news/canada/new-brunswick/vitalite-private-agency-travelling-nurses-6-million-horizon-government-union-1.6756940#:~:text=CBC%20News%20Loaded-,Use%20of%20private%20agency%20nurses%20at%20Vitalit%C3%A9%20spiked%20in%202022,the%20Right%20to%20Information%20Act

Cicellin, M., Iacono, M. P., Berni, A., & Esposito, V. (2015). Dealing with resistance in temporary agency nurses: The role of fear in identity-building processes. *Journal of Health Organization and Management*, 29(3), 298-316.

College of Nurses of Ontario. (2024). *Nursing Data Dashboard*. data.cno.org/

Coppolino, J. (2023, November 13). Shamji holding 'Sylvia Jones's feet to the fire' after nursing agency regulation bill defeated. *QP Briefing*. https://www.qpbriefing.com/news/shamji-holding-sylvia-jones-s-feet-to-the-fire-after-nursing-agency-regulation-bill-defeated

Cozad, M. J., Lindley, L. C., & Mixer, S. J. (2016). Using agency nurses to fill RN vacancies within specialized hospice and palliative care. *Policy, Politics, & Nursing Practice, 17(3)*, 147-155.

Daflos, P. (2022, August 25). 'A disaster': $64M in a single year to for-profit B.C. nursing companies amid 7-fold increase. *CTV News Vancouver*. https://bc.ctvnews.ca/a-disaster-64m-in-a-single-year-to-for-profit-b-c-nursing-companies-amid-7-fold-increase-1.6043113

Daflos, P. (2023a, May 30). B.C care homes propped up by for-profit staffing agencies 'near breaking point'. *CBC News Vancouver*. https://bc.ctvnews.ca/b-c-care-homes-propped-up-by-for-profit-staffing-agencies-near-breaking-point-1.6420103

Daflos, P. (2023b, September 12). B.C.'s health-care crisis: First look at massive markups by 'parasitic' staffing industry. *CTV News Vancouver*. https://bc.ctvnews.ca/b-c-s-health-care-crisis-first-look-at-massive-markups-by-parasitic-staffing-industry-1.6559044

Daflos, P. (2024a, June 18). Explosion in reliance on for-profit health-care staffing agencies in B.C. *CTV News Vancouver.* https://bc.ctvnews.ca/explosion-in-reliance-on-for-profit-health-care-staffing-agencies-in-b-c-1.6932287

Daflos, P. (2024b, June 19). Poor use of B.C. taxpayer dollars or necessary health-care expense? Critics slam secrecy and soaring costs. *CTV News Vancouver.* https://bc.ctvnews.ca/mobile/poor-use-of-b-c-taxpayer-dollars-or-necessary-health-care-expense-critics-slam-secrecy-and-soaring-costs-1.6933865?cache=yes/7.553613

De Ruyter, A. (2007). Should I stay or should I go? Agency nursing work in the UK. *International Journal of Human Resource Management*, 18(9), 1666–1683. https://www.tandfonline.com/doi/abs/10.1080/09585190701570742

Drost, A., Ben-Ahmed, H. E., & Sweetman, A. (2024). The trajectory of agency-employed nurses in Ontario, Canada: A longitudinal analysis (2011–2021). *Policy, Politics, & Nursing Practice*, 1–13. https://journals.sagepub.com/doi/10.1177/15271544241240489

Ferguson, R. (2024, January 18). Ford government slammed for Ontario's use of temporary nurses. *Toronto Star*. https://www.thestar.com/politics/provincial/ford-government-slammed-for-ontarios-use-of-temporary-nurses/article_c86e2b9e-b635-11ee-9dde-4764ccc28e12.html

Francis, J., Florko, L., & Thibault, T. (2022). *Talent trends: Languishing and the great attrition.* Conference Board of Canada. https://www.conferenceboard.ca/product/talent-trends-languishing-and-the-great-attrition/

Fraser Health Authority. (2024). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act.* File No. 2024-0788.

French, J. (2023, February 6). Alberta's reliance on contract nurses could further erode health-care system, critics say. *CBC News*. https://www.cbc.ca/news/Canada/edmonton/alberta-dependent-on-contract-nurses-1.6735424

French, J. (2024, January 9). Nurses union raises alarm about new overtime restrictions at Alberta Health Services. *CBC News*. https://www.cbc.ca/amp/1.7079010

GoHealth BC. (2024). *About GoHealth BC*. https://www.gohealthbc.ca/

Gorman, M. (2023, December 4). Nova Scotia government to limit the use of travel nurses. *CBC News*. https://www.cbc.ca/news/Canada/nova-scotia/health-care-travel-nurses-michelle-thompson-janet-hazelton-1.7048835

Gorman, M. (2024, March 19). Nurses' union president says 'unsustainable pressure' driving some from the profession. *CBC News*. https://www.cbc.ca/news/Canada/nova-scotia/health-care-staffing-nures-janet-hazelton-government-1.7148557

Government of Canada. (2024a). *CanadaBuys: Federal contracting information* https://Canadabuys.Canada.ca/en/tender-opportunities?category%5B154%5D=154&location%5B0%5D=1218¤t_tab=c&record_per_page=200&words=Nursing

Government of Canada. (2024b). *Nursing retention toolkit: Improving the working lives of nurses in Canada*. https://www.Canada.ca/en/health-Canada/services/health-care-system/health-human-resources/nursing-retention-toolkit-improving-working-lives-nurses.html

Government of Ontario. (2024, June 7). *Your guide to the Employment Standards Act: Recent changes. Temporary help agency and recruiter licensing*. https://www.ontario.ca/document/your-guide-employment-standards-act-0/recent-changes#:~:text=Beginning%20on%20July%201%2C%202024,the%20agency%20holds%20a%20licence

Government of Nova Scotia. (2023, December 4). *New approach to hiring travel nurses.* https://news.novascotia.ca/en/2023/12/04/new-approach-hiring-travel-nurses#:~:text=Premier%20Tim%20Houston%20announced%20today,for%20a%20maximum%20180%20days

Government of Saskatchewan. (2008, June 19). *Job guarantee and mentorship to keep and attract nurses.* https://www.saskatchewan.ca/government/news-and-media/2008/june/19/job-guarantee-and-mentorship-to-keep-and-attract-nurses

Grant, K. (2023a, July 24). Ontario spending on private nursing agencies quadrupled since COVID-19, data show. *Globe and Mail*. https://www.theglobeandmail.com/Canada/article-ontario-hospitals-private-nurses/

Grant, K. (2023b, December 7). Ontario government is not adequately tracking spending on private agency nurses as use skyrockets. *Globe and Mail.* https://www.theglobeandmail.com/Canada/article-ontario-government-is-not-adequately-tracking-spending-on-private/

Grant, K. (2024, February 20). Newfoundland seeks answers after 'shocking' spending on temporary nurses. *Globe and Mail*. https://www.theglobeandmail.com/Canada/article-newfoundland-and-labrador-health-minister-orders-investigation-of/

Grant, K. & Ha, T. T. (2024, April 16). Ottawa must regulate private nursing agencies, N.B. health network says. *Globe and Mail*. https://www.theglobeandmail.com/Canada/article-new-brunswick-private-nursing-regulation-budget/

Greig, K. (2024, February 21). Can Quebec lure more nurses back into the public system after going private? *CTV News*. https://montreal.ctvnews.ca/can-quebec-lure-more-nurses-back-into-the-public-system-after-going-private-1.6778169

Ha, T. T. (2024a, March 28). Newfoundland's Auditor General probing province's expensive travel nursing contracts. *Globe and Mail*. https://www.theglobeandmail.com/Canada/article-newfoundlands-Auditor General-probing-provinces-expensive-travel/

Ha, T. T. (2024b, February 19). Nurses' unions call for Auditor General probes into public contracts with private staffing agencies. *Globe and Mail*. https://www.theglobeandmail.com/Canada/article-nurses-unions-call-for-Auditor General-probes-into-public-contracts/

Ha, T. T. & Grant, K. (2024, May 2). Newfoundland faces health care staffing crunch after private agency won't release its travel nurses. *Globe and Mail*. https://www.theglobeandmail.com/Canada/article-newfoundland-faces-health-care-staffing-crunch-after-private-agency/

Ha, T. T., Grant, K., & Chambers, S. (2024, February 16). Have nurses, will travel. *Globe and Mail*. https://www.theglobeandmail.com/Canada/article-how-canadian-hospitals-grew-dependent-on-expensive-out-of-town-nurses/

Health Employers Association of British Columbia (2024). *Agency nurse utilization report*. Shared with British Columbia Nurses' Union per Appendix O – Provincial Collective Agreement between HEABC and the Nurses' Bargaining Association.

Health PEI. (2024). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act*. File No. 2024-16.

Hult, M., Halminen, O., Mattila-Holappa, P., & Kangasniemi, M. (2022). Health and work well-being associated with employment precariousness among permanent and temporary nurses: A cross-sectional survey. *Nordic Journal of Nursing Research, 42*(3), 140–146. https://doi.org/10.1177/20571585211070376

Hunter, A. (2024, May 8). 'It's only getting worse': Nurses' union president says new survey paints grim picture of health care in Sask. *CBC News*. https://www.cbc.ca/news/Canada/saskatchewan/sask-nurses-survey-1.7197895

Interlake-Eastern Regional Health Authority. (2024). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act*. File No. 2023-2024-23.

Jones, A. (2024, March 25). Ontario hospitals, LTC homes spent nearly $1B on agency staff last year. *Global News*. https://globalnews.ca/news/10381647/ontario-hospitals-ltc-homes-spent-agency-staff/amp/

Kaasalainen, S. (2023, May 18). Nursing agencies cashing in on staffing shortages. *The Hamilton Spectator*. https://www.thespec.com/opinion/contributors/nursing-agencies-cashing-in-on-staffing-shortages/article_2476b590-89cc-5268-8c11-0084e32fd465.html

Kennedy, A. (2024, March 24). Expanding nursing locum pilot program would fill health-care gaps across N.L., says union. *CBC News*. https://www.cbc.ca/news/Canada/newfoundland-labrador/registered-nurses-locum-pilot-program-1.7149743

Laberge, T. (2023, April 18). Quebec passes bill to limit use of private health agencies. *Montreal Gazette*. https://montrealgazette.com/news/quebec/quebec-passes-bill-to-limit-use-of-private-health-agencies

Labrador-Grenfell Health. (2022, August 24). *Registered Nurse locum premium policy*. https://www.lghealth.ca/wp-content/uploads/2022/09/RN-Locum-Travel-Premium-Policy.pdf

Lapointe, S. (2023, December 5). New Brunswick Nurses Union asks province to end travel nurse usage. *Global News*. https://globalnews.ca/news/10149626/new-brunswick-nurses-union-travel-nurses/

Legislative Assembly of Ontario. (2019). *Bill 124, Protecting a Sustainable Public Sector for Future Generations Act, 2019. Explanatory Note*. https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-124

Legislative Assembly of Ontario. (2023a). *Bill 67, Temporary Nursing Agency Licensing and Regulation Act, 2023*. https://www.ola.org/en/legislative-business/bills/parliament-43/session-1/bill-67

Legislative Assembly of Ontario. (2023b). *Bill 144, Healthcare Staffing Agencies Act, 2023*. https://www.ola.org/en/legislative-business/bills/parliament-43/session-1/bill-144

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: Advancing the methodology. *Implementation Science, 5*, 69.

Luck, S. (2022, November 17). N.S. spending tens of millions of dollars on private nursing companies for long-term care. *CBC News*. https://www.cbc.ca/news/Canada/nova-scotia/nova-scotia-private-nursing-spending-millions-1.6652118

MacEachern, D. (2023, April 6). Health authorities spent $100M on travel nurse contracts in past year: Documents. *CBC News*. https://www.cbc.ca/news/canada/newfoundland-labrador/travel-nurses-1.6802696#:~:text=NL-,Health%20authorities%20spent%20%24100M%20on%20travel%20nurse%20contracts%20in,numbers%20obtained%20by%20CBC%20News.

Manias, E., Aitken, R., Peerson, A., Parker, J., & Wong, K. (2003a). Agency-nursing work: perceptions and experiences of agency nurses. *International Journal of Nursing Studies, 40*(3), 269-279.

Manias, E., Aitken, R., Peerson, A., Parker, J., & Wong, K. (2003b). Agency nursing work in acute care settings: perceptions of hospital nursing managers and agency nurse providers. *Journal of Clinical Nursing, 12*(4), 457-466.

Manitoba Government. (2023). *News Release: Manitoba Governments new nursing float pool supports patient care in rural, northern communities*. https://news.gov.mb.ca/news/index.html?item=59259&posted=2023-05-09

Manitoba Nurses Union. (2024). *Agency Usage by RHA = FY 2017-18 to present* [Unpublished raw data].

Matlakala, M. C., & Botha, A. D. (2016). Intensive care unit nurse managers' views regarding nurse staffing in their units in South Africa. *Intensive and Critical Care Nursing*, 32, 49-57.

May, K. (2024, April 12). Agency nurse spending on track for record high. *Winnipeg Free Press*. https://www.winnipegfreepress.com/breakingnews/2024/04/12/agency-nurse-spending-on-track-for-record-high

Mazurenko, O., Liu, D., & Perna, C. (2015). Patient care outcomes and temporary nurses. *Nursing Management*, 46(8), 32-38.

McPhee, J. (2023, April 10). Private nursing bill skyrockets in Nova Scotia amid staffing crisis. *Saltwire*. https://www.saltwire.com/atlantic-Canada/news/private-nursing-bill-skyrockets-in-nova-scotia-amid-staffing-crisis-100842124/

Newhouse, R. P., Johantgen, M., Pronovost, P. J., & Johnson, E. (2005). Perioperative nurses and patient outcomes -- mortality, complications, and length of stay. *AORN Journal, 81*(3), 508-528.

Northern Health Region. (2024). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act*. File No. F2324-50.

Northwest Territories Legislative Assembly. (2024, May 23). *Additional information for return to written question 4-20*(1). https://www.ntlegislativeassembly.ca/sites/default/files/tabled-documents/2024-05/TD%2086-20%281%29%20Additional%20Information%20for%20Return%20to%20WQ%204-20%281%29.pdf

Nova Scotia Seniors and Long-Term Care. (2022). *Access to information under the Freedom of Information and Protection of Privacy Act*. File No. 2022-01289-SLTC. https://openinformation.novascotia.ca/FOI-Requests/2022-01289-SLTC/k7gq-ansv/about_data

Nova Scotia Seniors and Long-Term Care. (2023). *Access to information under the Freedom of Information and Protection of Privacy Act*. File No. 2023-00008-SLTC. https://openinformation.novascotia.ca/FOI-Requests/2023-00008-SLTC/pcaj-u84r/about_data

Office of the Auditor General of Ontario. (2023a, December). *Value-for-money audit: Hospitals in Northern Ontario: Delivery of timely and patient-centred care*. https://www.auditor.on.ca/en/content/annualreports/arreports/en23/AR_hospitalsnorth_en23.pdf

Office of the Auditor General of Ontario. (2023b, December). *Value-for-money audit: Long-Term Care Homes: Delivery of Resident-Centred Care*. https://www.auditor.on.ca/en/content/annualreports/arreports/en23/AR_LTCresidential_en23.pdf

Ontario Nurses' Association. (2023). *Agency Data Summary*. [Unpublished Raw Data].

Peerson, A., Aitken, R., Manias, E., Parker, J., & Wong, K. (2002). Agency nursing in Melbourne, Australia: a telephone survey of hospital and agency managers. *Journal of Advanced Nursing, 40*(5), 504-512.

Pham, J. C., Andrawis, M., Shore, A.D., Fahey, M., Morlock, L., & Pronovost, P.J. (2010). Are temporary staff associated with more severe emergency department medication errors? *Journal for Healthcare Quality, 33*(4), 9-18.

Prairie Mountain Health. (2024). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act*. File No. PMH 2023-2024-32.

Prisciak, D. (2024, March 14). Saskatchewan's use of travel nurses questioned, as SUN predicts $70M to be spent in 2024 alone. *CTV News Regina*. https://regina.ctvnews.ca/saskatchewan-s-use-of-travel-nurses-questioned-as-sun-predicts-70m-to-be-spent-in-2024-alone-1.6807052

Quinn, M. (2024, March 28). No-poaching clause means travel nurses can't accept jobs in N.L. *CBC News*. https://www.cbc.ca/news/Canada/newfoundland-labrador/travel-nurses-newfoundland-labrador-1.7156835

Rispel, L.C. & Moorman, J. (2015). The indirect costs of agency nurses in South Africa: A case study in two public sector hospitals. *Global Health Action, 8*(1), 26494, DOI: 10.3402/ghav8.26494.

Ronnie, L. (2020). Us and them: Experiences of agency nurses in intensive care units. *Intensive and Critical Care Nursing, 56,102764*. DOI: https://doi.org/10.1016/j.iccn.2019.102764.

Ross, S. (2023, April 27). Travel nurses will help fill summer gaps on PEI but higher pay called 'disheartening'. *CBC News*. https://www.cbc.ca/news/Canada/prince-edward-island/pei-travel-nurses-1.6822930

Royal Society of Canada. (2022). *Investing in Canada's nursing workforce post-pandemic: A call to action*. https://rsc-src.ca/sites/default/files/Nursing%20PB_EN.pdf

Rukavina, S. (2024, May 2). Private health agencies in Quebec launch legal challenge to new law limiting their use. *CBC News*. https://www.cbc.ca/news/Canada/montreal/private-health-care-agencies-quebec-lawsuit-1.7192184

Ruttle, J. (2023, May 30). Short-term nurses creating a long-term care 'crisis': Group. *Vancouver Sun*. https://vancouversun.com/health/local-health/short-term-nurses-crisis-bc-long-term-care-home-operators

Sanders, C. (2023, May 10). Manitoba's reliance on private nurses skyrocketed in 2022. *Winnipeg Free Press*. https://www.winnipegfreepress.com/breakingnews/2023/05/10/manitobas-reliance-on-private-nurses-skyrocketed-in-2022

Sanders, C. (2024a, June 7). More nurses wading into float pool to ease shortage. *Winnipeg Free Press*. https://www.winnipegfreepress.com/breakingnews/2024/06/07/more-nurses-wading-into-float-pool-to-ease-shortage

Sanders, C. (2024b, May 23). Province targets health regions' reliance on private-agency nurses. *Winnipeg Free Press*. https://www.winnipegfreepress.com/breakingnews/2024/05/23/province-targets-health-regions-reliance-on-private-agency-nurses

Saskatchewan Union of Nurses. (2023). *Request to Saskatchewan Health Authority for Access to Information under Local Authority Freedom of Information and Protection of Privacy Act*. File No. 23-24-00783

Saskatchewan Union of Nurses. (2024). *Request to Saskatchewan Health Authority for Access to Information under Local Authority Freedom of Information and Protection of Privacy Act*. File No. 23-24-1888

SEIU Healthcare. (2023, April 25). *Poll finds more than 60% of registered practical nurses are being driven out of healthcare*. https://seiuhealthcare.ca/poll-finds-more-than-60-of-registered-practical-nurses-are-being-driven-out-of-healthcare/

Simpson, K., & Simpson, R. (2019). What do we know about our agency nurse population? A scoping review. *Nursing Forum*, *54*(4), 492–498. https://doi.org/10.1111/nuf.12361

Southern Health-Santé Sud. (2024). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act*. File No. 022-23-24.

Statistics Canada. (2023). *Quality of employment and labour market dynamics of health care workers during the COVID-19 pandemic*. https://www150.statcan.gc.ca/n1/pub/75-006-x/2023001/article/00007-eng.htm

Statistics Canada. (2024a). *Table 14-10-0328-01: Job vacancies, proportion of job vacancies and average offered hourly wage by selected characteristics, quarterly, unadjusted for seasonality, inactive*. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1410032801

Statistics Canada. (2024b). *Table 14-10-0443-01: Job vacancies, proportion of job vacancies and average offered hourly wage by occupation and selected characteristics, quarterly, unadjusted for seasonality*. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1410044301

The Government of Newfoundland and Labrador. (2023, November 16). *Improving access to early learning and child care for health professionals.* https://www.gov.nl.ca/releases/2023/exec/1116n04/

United Nurses of Alberta. (2021, September 4). *AHS informs UNA it will use contract agencies to hire nurses during pandemic fourth wave.* https://www.una.ca/1284/ahs-informs-una-it-will-use-contract-agencies-to-hire-nurses-during-pandemic-fourth-wave-#:~:text=In%20an%20email%20to%20UNA,of%20the%20COVID%2D19%20pandemic

United Nurses of Alberta. (2022a). *UNA and AHS renew northern locum program, raising pay premium from $6 to $25 per hour*. https://www.una.ca/1390/una-and-ahs-renew-northern-locum-program-raising-pay-premium-from-6-to-25-per-hour

United Nurses of Alberta. (2022b). Letter of understanding between Alberta Health Services and the United Nurses of Alberta. https://www.una.ca/document/lou-north-zone-locum

Vancouver Coastal Health. (2024a). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act*. File No. 24-F-100

Vancouver Coastal Health. (2024b). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act.* File No. 24-F-101

Vancouver Coastal Health. (2024c). *Request for Access to Information under The Freedom of Information and Protection of Privacy Act*. File No. 24-F-102

Whittington, L. (2024, February 28). A dire nursing shortage, private-sector windfall profits all part of Ford's disastrous approach to Ontario health care. *The Hill Times*. https://www.hilltimes.com/story/2024/02/28/a-dire-nursing-shortage-private-sector-windfall-profits-all-part-of-fords-disastrous-approach-to-ontario-health-care/413068/#:~:-text=Bill%20124%20contributed%20to%20a,huge%20windfall%20of%20public%20cash.&text=O.

Williams, O. (2024, May 28). NWT's agency nurse usage will now be more closely watched. *Cabin Radio*. https://cabinradio.ca/184792/news/health/nwts-agency-nurse-usage-will-now-be-more-closely-watched/

Yalnizyan, A. (2023, July 26). Ontario's solution to the health care crisis is to hire nurses through agencies — and the cost has now quadrupled. *Toronto Star*. https://www.thestar.com/business/ontario-s-solution-to-the-health-care-crisis-is-to-hire-nurses-through-agencies-and/article_314ce082-9cf7-5e99-9ebe-727a00df7129.html

Yarr, K. (2023, October 30). Canada's medical system 'severely damaged' by use of nursing agencies, Gardam warns. *CBC News*. https://www.cbc.ca/news/Canada/prince-edward-island/pei-nurse-agency-costs-1.7012479

Young, S. (2024, June 10). Temporary help agency RPNs are subject to a hospital's collective agreement. *BLG*. https://www.blg.com/en/insights/2024/06/temporary-help-agency-rpns-are-subject-to-a-hospitals-collective-agreement

Appendix A: Summary of agency use for each jurisdiction with available data

This appendix provides a summary of the available data obtained and data sources used in this report for individual provinces and territories.

British Columbia

Data sources used in report

Media articles

1. Barter (2024a)
   - 2023–2024: total agency costs for Provincial Health Services Authority
2. Daflos (2022)
   - 2018–2019 and 2021–2022: total agency costs and names of agencies used by five health authorities
   - 2021–2022: hourly agency rate
   - 2023–2024: factors affecting hourly agency rates
3. Daflos (2023b)
   - 2022–2023: hourly agency rate
4. Daflos (2024a; 2024b)
   - 2018–2019 to 2022–2023: total agency costs used by five health authorities
5. Ruttle (2023)
   - 2023–2024: hourly agency rate

Several other media articles were found but data not used due to overlap with other data sources.

ATIP/FOI requests

1. Fraser Health Authority (2024)
   - 2020–2021 to 2023–2024: total agency costs; total agency hours; number of nurses from agencies
   - 2021–2022 to 2023–2024: hourly agency rates by RN, LPN, NP; factors affecting hourly agency rates
   - 2023–2024: frequently used practice areas; names/numbers of agencies used
2. Vancouver Coastal Health (2024a; 2024b; 2024c)
   - 2018–2019 to 2023–2024: total agency costs
   - 2020–2021 to 2023–2024: names/numbers of agencies used

- 2021–2022 to 2023–2024: hourly agency rates by RN, LPN, NP; factors affecting hourly agency rates
- 2023–2024: Total agency hours; frequently used practice areas

Provincial nurses union
British Columbia Nurses' Union shared data from the Health Employers Association of British Columbia (2024) data

- 2021–2022 to 2023–2024: quarterly agency hours by RN and LPN for six health authorities
- 2016–2017 to 2023–2024: quarterly agency hours (nurses) for province

Summary of results

agencies: 58 agencies working in province based on media articles, surveys, ATIP/FOI requests

nurses reporting nursing agencies as primary workplace on annual regulator registration (CIHI data)

- 2018 — 173 RNs, 130 LPNs
- 2019 — 194 RNs, 118 LPNs
- 2020 — 231 RNs, 125 LPNs
- 2021 — 230 RNs, 136 LPNs
- 2022 — 279 RNs, 175 LPNs

Provincial Health Services Authority
- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2023–2024 — 1.9M estimated
  - Data for remaining years not available
- Total agency hours: not available
- Hourly agency rates: not available

Fraser Health Authority
- # agencies
  - 2020 to 2023 not available
  - 2023–2024 — 17 agencies
- # nurses from agencies
  - 2020–2021 — 161
  - 2021–2022 — 494
  - 2022–2023 — 484
  - 2023–2024 — 365 (3 quarters)
- Total costs of agencies
  - 2018–2019 — 3M
  - 2019–2020 — 2M

- 2020–2021 — 4.7M
- 2021–2022 — 11.8M
- 2022–2023 — 14.7M
- 2023–2024 — 13.4M estimated
- Total agency hours
  - 2020–2021 — 44,297
  - 2021–2022 — 127,943
  - 2022–2023 — 151,589
  - 2023–2024 — 126,320 estimated
- Hourly agency rates
  - 2023–2024
    - General RN: $71.84; Specialty RN: $74.42; RN certified practice: $77.09
    - RPN: $74.42; LPN: $61.32; NP: $82.21
    - See Appendix J for additional years and direct and indirect costs

Vancouver Coastal Health

- # agencies
  - 2020–2021 — 2 agencies
  - 2021–2022 — 7 agencies
  - 2022–2023 — 14 agencies
  - 2023–2024 — 16 agencies
- # nurses from agencies
  - 2020–2021 to 2021–2022 — not available
  - 2022–2023 — 243
  - 2023–2024 — 812 (3 quarters)
- Total costs of agencies
  - 2018–2019 — 4.2M
  - 2019–2020 — 6M
  - 2020–2021 — 4.6M
  - 2021–2022 — 6.1M
  - 2022–2023 — 24.1M
  - 2023–2024 — 27.4M estimated
- Total agency hours
  - 2021–2022 — 50,574
  - 2022–2023 — 177,556
  - 2023–2024 — 325,404 estimated
- Hourly agency rates
  - 2023–2024
    - General RN: $71.84; RPN: $74.42; LPN: $61.32; NP: $82.21
    - One agency charged $93–110 for specialty RNs
    - See Appendix J for additional years and direct and indirect costs

Interior Health

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2018–2019 — 1M

  - 2019-2020 — 2M
  - 2020-2021 — 1.3M
  - 2021-2022 — 8.5M
  - 2022-2023 — 34.4M
  - 2023-2024 — not available
- Total agency hours
  - 2021-2022 — 78,953
  - 2022-2023 — 280,704
  - 2023-2024 — 283,951 estimated
- Hourly agency rates: not available

Northern Health
- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2018-2019 — 4.6M
  - 2019-2020 — 8.6M
  - 2020-2021 — 12.6M
  - 2021-2022 — 27.2M
  - 2022-2023 — 52M
  - 2023-2024 — not available
- Total agency hours
  - 2021-2022 — 182,984
  - 2022-2023 — 306,144
  - 2023-2024 — 399,341 estimated
- Hourly agency rates: not available

Vancouver Island Health
- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2018-2019 — 0
  - 2019-2020 — 0
  - 2020-2021 — 5.7M
  - 2021-2022 — 20.1M
  - 2022-2023 — 37.5M
  - 2023-2024 — not available
- Total agency hours
  - 2021-2022 — 225,359
  - 2022-2023 — 406,593
  - 2023-2024 — 565,016 estimated
- Hourly agency rates: not available

Providence Health Care
- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies: not available

- Total agency hours
  - 2021-2022 — 12,616
  - 2022-2023 — 23,232
  - 2023-2024 — 18,039 estimated
- Hourly agency rates: not available

Provincial initiatives

1. GoHealth BC is a collaborative effort between Northern Health, Interior Health, Island Health, the Ministry of Health and the British Columbia Nurses' Union to create a flexible approach to help provide nurses to rural and remote communities. https://www.gohealthbc.ca/

2. A health authority in British Columbia reported that the hourly agency rates were regulated by the provincial health authority.

Alberta

Data sources used in report

Media articles

1. French (2023)
   - 2015-2016 to 2021-2022: total agency costs and numbers of agencies used by Alberta Health Services
   - 2021-2022 to 2022-2023: total agency costs and numbers of agencies used by Covenant Health
   - 2022-2023: hourly agency rate, number of nurses from agencies, frequently used practice areas
2. United Nurses of Alberta (2021)
   - 2020-2021: names of agencies used
3. Alberta Health Services (2022) website
   - 2020-2021 to 2021-2022: names of agencies used

Summary of results

agencies: 48 agencies working in province based on media articles, surveys and Alberta Health Services website

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)

- 2018 — 129 RNs, 1-4 LPNs
- 2019 — 141 RNs, 0 LPNs
- 2020 — 144 RNs, 1-4 LPNs
- 2021 — 148 RNs, 1-4 LPNs
- 2022 — 168 RNs, 5 LPNs

Alberta Health Services

- # agencies
  - 2020-2021 — 5 agencies
  - 2021-2022 — 10 agencies
  - 2022 to 2024 — not available
- # nurses from agencies
  - 2020-2021 to 2021-2022 — not available
  - 2022-2023 — 341 RNs, LPNs and health care aides
  - 2023-2024 — not available
- Total costs of agencies
  - 2018-2019 — 0.4M
  - 2019-2020 — 2.7M
  - 2020-2021 — 5M
  - 2021-2022 — 5.1M
  - 2022 to 2024 — not available
- Total agency hours: not available
- Hourly agency rates: not available

Covenant Health

- # agencies
  - 2020-2021 — not available
  - 2021-2022 — 5 agencies
  - 2022-2023 — 7 agencies
  - 2023-2024 — not available
- # nurses from agencies
  - 2020-2021 to 2021-2022 — not available
  - 2022-2023 — 35 RNs and LPNs
  - 2023-2024 — not available
- Total costs of agencies
  - 2021-2022 — 0.3M
  - 2022-2023 — 2.2M (3 quarters only)
  - Data for remaining years not available
- Total agency hours: not available
- Hourly agency rates: not available

Rural and remote locations – hourly agency rate was posted as $85/hr in 2022-2023.

Provincial Initiatives

- The RN/RPN Locum Program is focused on providing staffing for facilities and programs operating in the North Zone of Alberta Health Services for short-term periods of less than 12 months (https://www.una.ca/1390/una-and-ahs-renew-northern-locum-program-raising-pay-premium-from-6-to-25-per-hour).

Saskatchewan

Data sources used in report

Media articles
Prisciak (2024)
- 2020–2021: total agency costs
- 2023–2024: names of agencies used

Other media articles were found but data not used due to overlap with other data sources.

Provincial nurses union
Saskatchewan Union of Nurses (2023, 2024)
- 2021–2022 to 2023–2024: total agency costs; total agency hours; hourly agency rate
- 2023–2024: frequently used practice areas; names/numbers of agencies used

Summary of results

agencies: 17 agencies working in province based on media articles, surveys and data available from the Saskatchewan Union of Nurses

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)

- 2018 — 31 RNs, 21 LPNs
- 2019 — 33 RNs, 14 LPNs
- 2020 — 34 RNs, 13 LPNs
- 2021 — 44 RNs, 10 LPNs
- 2022 — 45 RNs, 10 LPNs

Saskatchewan Health Authority
- # agencies
  - 2020–2023 — not available
  - 2023–2024 — 15 agencies
- # nurses from agencies: not available
- Total costs of agencies
  - 2020–2021 — 1.4M (3 agencies only)
  - 2021 — 12.3M
  - 2022 — 45.3M
  - 2023 — 59.2M
- Total agency hours
  - 2021 — 102,500
  - 2022 — 377,899
  - 2023 — 493,188
- Hourly agency rates
  - 2021 to 2024 — $120/hr

Provincial initiatives — none found

Manitoba

Data sources used in report

Media articles
Several media articles were found but data not used due to overlap with other data sources.

ATIP/FOI requests
1. Prairie Mountain Health (2024)
   - 2020–2021 to 2023–2024: total agency costs by RN and LPN (worked time, travel time, mileage/accommodations); total agency hours by RN and LPN (worked, travel); hourly agency rate by RN, LPN and NP; factors affecting hourly agency rates; number of agencies used.
   - 2023–2024: frequently used practice areas.
2. Southern Health–Santé Sud (2024)
   - 2020–2021 to 2023–2024: total agency costs by RN and LPN; total agency hours by RN and LPN.
   - 2022–2023 to 2023–2024: hourly agency rate by RN, LPN and NP; factors affecting rates.
   - 2023–2024: hourly agency rate by RN, LPN and NP; factors affecting hourly agency rates; frequently used practice areas; names/numbers of agencies used.
3. Northern Health Region (2024)
   - 2020–2021 to 2023–2024: total agency costs by RN, LPN, RPN (compensation, travel and other expenses); total agency hours by RN and LPN; hourly agency rate by RN, LPN and RPN; factors affecting hourly agency rates; frequently used practice areas; names/numbers of agencies used.
4. Interlake–Eastern Regional Health Authority (2024)
   - 2020–2021 to 2023–2024: total agency costs by RN and LPN; total agency hours by RN and LPN; hourly agency rate by RN and LPN; factors affecting hourly agency rates.
   - 2023–2024: frequently used practice areas; names/numbers of agencies used.

Provincial nurses union
Manitoba Nurses Union (2024)
- 2017–2018 to 2022–2023: total agency costs, total agency hours for Shared Health, Winnipeg Regional Health Authority, Prairie Mountain Health, Southern Health, Interlake Eastern.

Summary of results

agencies: 96 agencies working in province based on surveys and ATIP/FOI requests

nurses from agencies
- No data available for RNs
- 2018 — 30 LPNs

- 2019 — 37 LPNs
- 2020 — 47 LPNs
- 2021 — LPNs data not available
- 2022 — 75 LPNs

Shared Health

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2020-2021 — 63,330
  - 2021-2022 — 8,923
  - Data for remaining years not available)
- Total agency hours
  - 2020-2021 — 948
  - 2021-2022 — 131
- Hourly agency rates: not available

Winnipeg Regional Health Authority

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2018-2019 — 0.5M
  - 2019-2020 — 3.8M
  - 2020-2021 — 2.6M
  - 2021-2022 — 4.1M
  - 2022-2023 — 4.1M
  - Data for remaining years not available
- Total agency hours
  - 2019-2020 — 52,052
  - 2020-2021 — 35,803
  - 2021-2022 — 62,349
  - 2022-2023 — 63,835
  - 2023-2024 — 49,585 estimated
- Hourly agency rates: not available

Prairie Mountain Health

- # agencies
  - 2020-2021 — 8 agencies
  - 2021-2022 — 26 agencies
  - 2022-2023 — 30 agencies
  - 2023-2024 — 30 agencies
- # nurses from agencies: not available
- Total costs of agencies
  - 2018-2019 — 7.8M
  - 2019-2020 — 9.9M
  - 2020-2021 — 14M
  - 2021-2022 — 28M

  - 2022-2023 — 23.1M
  - 2023-2024 — 22.5M estimated
- Total agency hours
  - 2019-2020 — 127,482
  - 2020-2021 — 120,434
  - 2021-2022 — 190,338
  - 2022-2023 — 296,104
  - 2023-2024 — 287,693 estimated
- Hourly agency rates
  - 2021 to present
    - $65 RN, $50 LPN, $85 NP
    - See Appendix J for direct and indirect costs

Southern Health-Santé Sud

- # agencies
  - 2020-2021 — 10 agencies
  - 2021-2022 — 33 agencies
  - 2022-2023 — 38 agencies
  - 2023-2024 — 31 agencies
- # nurses from agencies: not available
- Total costs of agencies
  - 2018-2019 — 1.5M
  - 2019-2020 — 2.1M
  - 2020-2021 — 2.1M
  - 2021-2022 — 5.6M
  - 2022-2023 — 8.1M
  - 2023-2024 — 8.7M estimated
- Total agency hours
  - 2019-2020 — 27,811
  - 2020-2021 — 29,243
  - 2021-2022 — 77,477
  - 2022-2023 — 115,385
  - 2023-2024 — 113,597 estimated
- Hourly agency rates
  - 2022 to present
    - RN average: $78.40, range: $65.00-$162.50
    - LPN average: $66.15, range: $50.00-$125
    - NP average: $127.36, range: $85.00-$212.50
    - See Appendix J for direct and indirect costs

Northern Health Region

- # agencies
  - 2020-2021 — 15 agencies
  - 2021-2022 — 25 agencies
  - 2022-2023 — 45 agencies
  - 2023-2024 — 35 agencies
- # nurses from agencies: not available

- Total costs of agencies
  - 2018-2019 — 3.1M
  - 2019-2020 — 4M
  - 2020-2021 — 8M
  - 2021-2022 — 10.4M
  - 2022-2023 — 12.9M
  - 2023-2024 — 14.4M estimated
- Total agency hours
  - 2019-2020 — 65,803
  - 2020-2021 — 93,011
  - 2021-2022 — 115,160
  - 2022-2023 — 121,327
  - 2023-2024 — 128,745 estimated
- Hourly agency rates
  - 2021 to present
    - RN range $65-$130
    - LPN range $50-$100
    - RPN range $65-$130
    - See Appendix J for direct and indirect costs

Interlake-Eastern

- # agencies
  - 2020-2023 — not available
  - 2023-2024 — 58 agencies
- # nurses from agencies: not available
- Total costs of agencies
  - 2018-2019 — 3.7M
  - 2019-2020 — 4.3M
  - 2020-2021 — 6.7M
  - 2021-2022 — 7.7M
  - 2022-2023 — 11.5M
  - 2023-2024 — 14.7M estimated
- Total agency hours
  - 2019-2020 — 55,993
  - 2020-2021 — 86,564
  - 2021-2022 — 100,364
  - 2022-2023 — 151,516
  - 2023-2024 — 187,517 estimated
- Hourly agency rates
  - 2021 to present
    - $65 RN, $50 LPN, $85 NP
    - See Appendix J for direct and indirect costs

Provincial initiatives

1. Agency rates set by the province via the Provincial Multi Service Agency Agreement and Fee Schedule, and there was no negotiation on these rates with the agencies.

2. Provincial Nursing Float Pool provides nurses with flexibility in terms of length of assignment, choice of health region, work location and specialty area preferred. https://news.gov.mb.ca/news/index.html?item=59259&posted=2023-05-09

3. New tentative four-year contract includes a clause that prohibits nurses working for private nursing agencies from also picking up extra hours through the public system in the same health region.

4. The province is issuing a request for proposals for private nursing agencies to become validated by the province, allowing them to work with service providers in Manitoba.

Ontario

Data sources used in report

Media articles

1. Jones (2024)
   - 2021-2022 to 2022-2023: total agency costs for hospitals and LTC in province
2. Grant (2023a)
   - 2020-2021 to 2021-2022: total agency hours for hospitals
   - 2022-2023: total agency hours for northern hospitals
   - 2021-2022 to 2022-2023: hourly agency rates for hospitals; factors affecting hourly agency rates
3. Yalnizyan (2023)
   - 2020-2021: Total agency hours for hospitals

Several other media articles were found but data not used due to overlap with other data sources.

Advantage Ontario (2022, 2023) survey data

- 2022-2023: total agency costs for 100 LTC homes; hourly agency rates; factors affecting hourly agency rates
- 2021-2022 to 2023-2024: percentage increase in total agency hours from 2020

Provincial nurses union

Ontario Nurses' Association (2023)

- 2020-2021 to 2022-2023: total agency costs, total agency hours, hourly agency rates (RNs) for hospitals.

CNE surveys

- 14 hospitals reported that they do not use agencies

- 2020–2021 to 2023–2024: total agency costs, total agency hours by RN and LPN, number of nurses from agencies (four hospitals); names/number of agencies (one to five hospitals)
- 2023–2024: total agency hours (one hospital); hourly agency rates, factors affecting hourly agency rates and frequently used practice areas (six hospitals)

Summary of results

- # agencies: 90 agencies working in province based on media articles and surveys
- # nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)
  - 2018 — 2,246 RNs, 2,551 LPNs
  - 2019 — 2,083 RNs, 2,638 LPNs
  - 2020 — 2,091 RNs, 2,675 LPNs
  - 2021 — 1,762 RNs, 2,105 LPNs
  - 2022 — 1,885 RNs, 2,251 LPNs

Ontario hospitals and long-term care homes

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2021–2022 — 368.6M
  - 2022–2023 — 600.2M (projected)
- Total agency hours: not available

Long-term care homes

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2022–2023 — 6M/month
- Total agency hours: 586% (RN) and 587% (LPN) increase from 2020
- Hourly agency rates
  - 2022–2023
    - RN average: $97.33/hr; RN range $55/hr to $139.65/hr
    - Some homes were charged: RN: $210, LPN: $165
    - See Appendix J for direct and indirect costs

Ontario Nurses' Association data

- Total costs of agencies
  - 2020–2021 — 38.1M
  - 2021–2022 — 68.4M
  - 2022–2023 — 154M (3 quarters only)
- 2021–2023 — data from 129 hospitals
  - 2021 — 74 hospitals reported no spending on agencies
  - 2022 — 54 hospitals reported no spending on agencies

    - 2023 — 39 hospitals reported no spending on agencies during the first two quarters
    - Two regions reported the highest number of hospitals who were not using agencies — 14 hospitals in region 5 (Ontario Health West-Southwestern Ontario) and 12 hospitals in region 2 (Ontario Health East-Eastern Ontario).
- Total agency hours
    - 2020-2021 — 449,735
    - 2021-2022 — 649,002
    - 2022-2023 — 1.2M
    - 2022-2023 — Northern Hospitals approximately 391,000
- Hourly agency rates
    - 2022-2023
        - General RN average: $112.56
        - General RN range: $53.50-$260
        - Specialty RN average: $128.79
        - Specialty RN range: $81.20-$195
        - See Appendix J for direct and indirect costs

Hospitals (7 CNE surveys)

- # agencies
    - 2020-2021 — 1 agency
    - 2021-2022 — 1 to 5 agencies
    - 2022-2023 — 1 to 6 agencies
    - 2023-2024 — 2 to 7 agencies
    - Fourteen hospitals reported they do not use agencies
- # nurses from agencies from 4 hospitals
    - 2020-2021 — 17
    - 2021-2022 — 2 to 93
    - 2022-2023 — 2 to 175
    - 2023-2024 — 16 to 160 (3 quarters)

Hospital 1

- Total costs of agencies
    - 2020-2021 — 0
    - 2021-2022 — 0.1M
    - 2022-2023 — 57,600
    - 2023-2024 — 0
- Total agency hours
    - 2020-2021 — 0
    - 2021-2022 — 1,440
    - 2022-2023 — 720
    - 2023-2024 — 0
- Hourly agency rates
    - 2023-2024 — $80/hr
    - See Appendix J for direct and indirect costs

Hospital 2

- Total costs of agencies
  - 2020-2021 — 0
  - 2021-2022 — 0
  - 2022-2023 — 0.2M
  - 2023-2024 — 0.8M estimated
- Total agency hours
  - 2020-2021 — 0
  - 2021-2022 — 0
  - 2022-2023 — 1,187
  - 2023-2024 — 6,596 estimated
- Hourly agency rates
  - 2023-2024
    - Average RN: $127.30, range: $96.27-$156.90
    - Average LPN: $95.78, range: $67.45-$129.90
    - See Appendix J for direct and indirect costs

Hospital 3

- Total costs of agencies
  - 2020-2021 — 0
  - 2021-2022 — 0
  - 2022-2023 — 1M
  - 2023-2024 — 1.5M estimated
- Total agency hours
  - 2020-2021 — 0
  - 2021-2022 — 0
  - 2022-2023 — 9,245
  - 2023-2024 — 13,316 estimated
- Hourly agency rates
  - 2023-2024
    - Average RN: $104.50
    - Average LPN: $88
    - See Appendix J for direct and indirect costs

Hospital 4

- Total costs of agencies
  - 2020-2021 — 0
  - 2021-2022 — 1.2M
  - 2022-2023 — 2.6M
  - 2023-2024 — 4.5M estimated
- Total agency hours
  - 2020-2021 — 9,069
  - 2021-2022 — 69,948
  - 2022-2023 — 116,742
  - 2023-2024 — 207,193 estimated
- Hourly agency rates
  - 2023-2024

- Average RN: $108.23, range: $79.40–$120
- Average LPN: $89.42, range: $62.50–$109
- See Appendix J for direct and indirect costs

Hospital 5
- Total costs of agencies: not available
- Total agency hours
    - 2020 to 2022 — not reported
    - 2023–2024 — 9,071 estimated
- Hourly agency rates: not available

Hospital 6
- Total costs of agencies: not available
- Total agency hours: not available
- Hourly agency rates
    - 2023–2024 — $90/hr
    - See Appendix J for direct and indirect costs

Provincial initiatives

1. Bill 67: enacts the *Temporary Nursing Agency Licensing and Regulation Act*, 2023, which proposed to add a new licensing requirement for operators of temporary nursing agencies (Coppolino, 2023; Legislative Assembly of Ontario, 2023a). First reading was February 23, 2023, and second reading was November 1, 2023. The vote was lost on division.

2. Bill 144: enacts the H*ealthcare Staffing Agencies Ac*t, 2023, which proposed that every hospital and LTC home in a municipality with a population of 8,000 or more shall develop a plan to limit its spending on health care staffing agencies in accordance with a specified timeline (Casey, 2023; Legislative Assembly of Ontario, 2023b). First reading was October 31, 2023, ordered for second reading.

3. Other initiatives mentioned with little detail
    A. Ontario is reviewing pricing practices of nursing agencies involved in LTC homes. Long-Term Care Minister Paul Calandra said at the legislature that his deputy minister has formed a technical advisory committee to examine the issue in response to queries about price gouging by nursing agencies (Casey, 2023).

    B. The Ontario Ministry of Long-Term Care is examining the possibility of creating a vendor of record for approved LTC agencies to potentially support price regulation (Jones, 2024).

    C. Liberal MPP Adil Shamji asked government to conduct a value-for-money audit on the impact of temporary staff agencies in health care. NDP government also called for the capping of rates charged to hospitals by agencies (Ferguson, 2024).

4. Beginning on July 1, 2024, under the *Employment Standards Act*, 2000 (ESA): temporary help agencies are required to hold a licence to operate and clients are prohibited from

knowingly engaging or using the services of a temporary help agency unless the agency holds a licence (Government of Ontario, 2024).

5. Two value-for-money audits by Office of Attorney General of Ontario, which include data on agency use.
   A. Hospitals in Northern Ontario: Delivery of Timely and Patient-Centred Care (Office of the Auditor General of Ontario, 2023a)

   B. Long-Term Care Homes: Delivery of Resident-Centred Care (Office of the Auditor General of Ontario, 2023b)

Quebec

Data sources used in report

Media articles
1. Authier (2023)
   - 2016 to 2023: total agency costs for province for all agency staff
2. Grant and Ha (2024)
   - 2022-2023: total agency costs for province

Other media articles were found but data not used due to overlap with other data sources.

CNE surveys
- 2020-2021 to 2023-2024: total agency costs, total agency hours for RNs and LPNs, number of nurses from agencies, name/numbers of agencies used by six health authorities
- 2023-2024: hourly agency rates (RN and LPNs); factors affecting hourly agency rates; frequently used practice areas for six health authorities

Summary of results

agencies: 283 agencies working in province based on CNE surveys

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)
- 2018 — 1,228 RNs, 575 LPNs
- 2019 — 1,238 RNs, 578 LPNs
- 2020 — 1,416 RNs, 683 LPNs
- 2021 — 1,736 RNs, 868 LPNs
- 2022 — no data available for RNs, 851 LPNs

Nurses from agencies for 3 health authorities
- 2020-2021 — 341 to 1,140
- 2021-2022 — 476 to 1,484
- 2022-2023 — 499 to 1,161

- 2023–2024 — 208 to 1,696 (3 quarters)

Total costs of agencies in province
- 2016–2023 — 3B for all agency staff
- 2022–2023 — 578M

Health authority 1
- # agencies
  - 2020–2021 — 2 agencies
  - 2021–2022 — 4 agencies
  - 2022–2023 — 6 agencies
  - 2023–2024 — 7 agencies
- Total costs of agencies
  - 2020–2021 — 0.2
  - 2021–2022 — 0.3
  - 2022–2023 — 1.2M
  - 2023–2024 — 1.1M estimated
- Total agency hours
  - 2020–2021 — 2,546
  - 2021–2022 — 2,603
  - 2022–2023 — 13,646
  - 2023–2024 — 6,327 estimated
- Hourly agency rates
  - 2023–2024
    - Average RN: $117.94, range: $70.94–$140
    - See Appendix J for direct and indirect costs

Health authority 2
- # agencies
  - 2020–2021 — 33 agencies
  - 2021–2022 — 31 agencies
  - 2022–2023 — 35 agencies
  - 2023–2024 — 54 agencies
- Total costs of agencies
  - 2020–2021 — 15.8M
  - 2021–2022 — 36M
  - 2022–2023 — 54.8M
  - 2023–2024 — 57.6M estimated
- Total agency hours
  - 2020–2021 — 126,797
  - 2021–2022 — 278,537
  - 2022–2023 — 328,406
  - 2023–2024 — 357,745 estimated
- Hourly agency rates
  - 2023–2024
    - RN average: $127.44, range: $84.75–$165
    - LPN average: $91.77, range: $64–$125

    - See Appendix J for direct and indirect costs

Health authority 3

- # agencies
  - 2020-2021 — 93 agencies
  - 2021-2022 — 93 agencies
  - 2022-2023 — 92 agencies
  - 2023-2024 — 77 agencies
- Total costs of agencies
  - 2020-2021 — not reported
  - 2021-2022 — 3.1M
  - 2022-2023 — not reported
  - 2023-2024 — 35.1M estimated
- Total agency hours
  - 2020-2021 — not reported
  - 2021-2022 — 91,835
  - 2022-2023 — 110,073
  - 2023-2024 — 255,969 estimated
- Hourly agency rates
  - 2023-2024
    - RN average: $122.7, range: $78.99-$155
    - LPN average: $90.26, range: $60.44-$120
    - See Appendix J for direct and indirect costs

Health authority 4

- # agencies
  - 2020-2021 — 46 agencies
  - 2021-2022 — 64 agencies
  - 2022-2023 — 47 agencies
  - 2023-2024 — 36 agencies
- Total costs of agencies
  - 2020-2021 — 6.8M
  - 2021-2022 — 6.3M
  - 2022-2023 — 9M
  - 2023-2024 — 29.6M estimated
- Total agency hours
  - 2020-2021 — 96,460
  - 2021-2022 — 95,287
  - 2022-2023 — 113,743
  - 2023-2024 — 429,650 estimated
- Hourly agency rates
  - 2023-2024
    - RN average: $88.48
    - LPN average: $57.44
    - See Appendix J for direct and indirect costs

Health authority 5

- # agencies
  - 2020–2021 — 286 agencies
  - 2021–2022 — 283 agencies
  - 2022–2023 — 249 agencies
  - 2023–2024 — 262 agencies
- Total costs of agencies
  - 2020–2021 — 13M
  - 2021–2022 — 24.7M
  - 2022–2023 — 27.8M
  - 2023–2024 — 62.7M estimated
- Total agency hours
  - 2020–2021 — 157,743
  - 2021–2022 — 256,531
  - 2022–2023 — 283,201
  - 2023–2024 — 494,416 estimated
- Hourly agency rates
  - 2023–2024
    - RN average: $144.68, range: $69.75–$175
    - LPN average: $100.35, range: $69–$105
    - See Appendix J for direct and indirect costs

Health authority 6

- # agencies: not available
- Total costs of agencies
  - 2020–2021 — 41.7M
  - 2021–2022 — 36.6M
  - 2022–2023 — 39M
  - 2023–2024 — 90.7M estimated
- Total agency hours
  - 2020–2021 — 471,434
  - 2021–2022 — 540,143
  - 2022–2023 — 504,736
  - 2023–2024 — 659,221 estimated
- Hourly agency rates
  - 2023–2024
    - RN average: $129.95, range: $83–$160
    - LPN average: $90.03, range: $47.65–$105
    - See Appendix J for direct and indirect costs

Provincial initiatives

A. April 2023, Bill 10: aimed at "prohibiting" the use of the services of personnel placement agencies and independent labor (MOI) in the health and social services sector. Complete ban by December 2024 for major centers like Quebec City and Montreal, and December 2025 for the rest of the province (Laberge, 2023). It was reported in May 2024, that the Entreprises Privées de personnels soignants du Québec (EPPSQ), which

represents private health agencies in Quebec, has launched a legal challenge to Bill 10 (Rukavina, 2024).

B. Fall 2023/April 24: Single contract signed by the government to meet the needs of hospitals and CHSLDs. Quebec has grouped all the needs for hospitals and CHSLDs under a single contract which will now be managed by the Government Acquisition Center (CAG). This contract replaces the thousands of agreements signed over the years by health establishments, which until now negotiated their prices independently (Bellerose, 2024).

C. The province reached an agreement with the CSN union to allow nurses to maintain some seniority, meaning that if private sector nurses come back to work in the public sector, they can start their new job with up to five years of seniority (Greig, 2024).

New Brunswick

Data sources used in report

Media articles

1. Barter (2024b)
   - 2023–2024: total agency costs and total agency hours for Vitalité Health Network
2. CBC News (2023)
   - 2022–2023: total costs, total agency hours, hourly agency rates and factors affecting hourly agency rates for Vitalité Health Network
3. Ha (2024b)
   - 2022–2023: hourly agency rates and factors affecting hourly agency rates for Vitalité Health Network
4. Ha et al. (2024)
   - 2022–2023: hourly agency rates, factors affecting hourly agency rates, names of agencies for Vitalité Health Network

Several other media articles were found but data was not used due to overlap with other data sources.

Auditor General of New Brunswick (2024)

- 2021–2022 to 2023–2024: total agency costs, hourly agency rates and factors affecting hourly agency rates for contracted health care workers (RN, LPN, personal support workers) for Vitalité Health Network and Horizon Health Network
- 2022–2023: total agency costs, hourly agency rates and factors affecting hourly agency rates for contracted health care workers (RN, LPN, personal support workers) for Department of Social Development

CNE survey (one health authority)

- 2022–2023 to 2023–2024: total agency costs; total agency hours; hourly agency rate; factors affecting hourly agency rates; number of nurses from agencies; frequently used practice areas; number of nurses from agencies; names/numbers of agencies used

Summary of results

agencies: 26 agencies working in province based on media articles, surveys, ATIP/FOI requests

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)

- 2018 — 26 RNs, no data available for LPNs
- 2019 — 28 RNs, no data available for LPNs
- 2020 — 24 RNs, no data available for LPNs
- 2021 — 21 RNs, no data available for LPNs
- 2022 — 23 RNs, 55 LPNs

Two health authorities

- # agencies
    - 2020–2021 — 0 agencies
    - 2021–2022 — 2 agencies
    - 2022–2023 — 10 agencies
    - 2023–2024 — 11 agencies

Vitalité Health Network

- # nurses from agencies: not available
- Total costs of agencies
    - 2022–2023 — 5.9M in July to December — media reports
    - 2023–2024 — 117.4M estimated — media reports
    - January 1, 2022, to February 29, 2024 — 123M (RN, LPN, personal support workers) — Auditor General report
- Total agency hours
    - 2022–2023 — 20,098 July to December (3 agencies only)
    - 2023–2024 — 406,599 estimated
- Hourly agency rates
    - 2021 to present
        - 3 agencies: RN range — $120/hr–$169.6/hr
        - 2 agencies: LPN range — $90/hr–$124.8/hr
        - One agency only offered bundled pricing model. A team up to 12 hrs/day = $18,043.42 per team/day (one contract) or $18,403.42 per team/day (second contract). A team was comprised of virtual staff (1 operations lead, 1 clinical lead, 0.44 scheduler) and in person (0.22 logistics lead, 2 LPNs, 3 RNs). This was calculated as $306/hr for LPN or RN, which includes all non-direct care staffing costs.
        - See Appendix J for direct and indirect costs

Horizon Health Network

- # nurses from agencies
  - 2020-2021 to 2021-2022 — not available
  - 2022-2023 — 49
  - 2023-2024 — 403 (3 quarters)
- Total costs of agencies
  - 2022-2023 — 5M
  - 2023-2024 — 54.8M estimated
  - January 1, 2022, to February 29, 2024 — 48M — Auditor General report
- Total agency hours
  - 2022-2023 — 31,287
  - 2023-2024 — 314,724 estimated
- Hourly agency rates
  - 2022-2023 — average — $131, range $95-$170
  - 2023-2024 — average — RN $125, LPN $95
  - 2022 to present (Auditor General)
    - RN range: $85/hr-$160/hr
    - LPN range: $70/hr-$110/hr
  - See Appendix J for direct and indirect costs

Department of Social Development

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2022 — 2.9M February to July 2022
- Total agency hours: not available
- Hourly agency rates
  - 2022-2023
    - One agency: RN: $89.5/hr; LPN: $59.5/hr
    - One agency only offered bundled pricing model at $9,995/team/day, which included: 1) a team day up to 8 hrs/day; and 2) a team comprised of virtual staff (½ team lead, ½ clinical lead, 1 scheduler) and in-person staff (1 logistics manager, 5 certified PSWs, 1 RN, 1 LPN).
    - See Appendix J for direct and indirect costs

Provincial initiatives

- June 4, 2024: final report of the Auditor General of New Brunswick Volume I Performance Audit (Auditor General of New Brunswick, 2024) released, which was an independent audit of the management of contracts pertaining to travel nurses, which includes the regional health authorities, the Department of Social Development and the Department of Health. https://www.agnb-vgnb.ca/content/dam/agnb-vgnb/pdf/Reports-Rapports/2024V1/Agrepe.pdf?random=1717507778207

Nova Scotia

Data sources used in report

Media articles

1. Gorman (2024)
   - 2023–2024: total agency costs, number of nurses from agencies for Nova Scotia Department of Health
2. Luck (2022)
   - 2021–2022: hourly agency rates (RNs and LPNs) in LTC homes
3. McPhee (2023)
   - 2021–2022 to 2022–2023: total agency costs for RNs and LPNs for Nova Scotia Healt
   - 2022–2023: names/number of agencies used by Nova Scotia Health
4. Yarr (2023)
   A. 2020–2021 to 2021–2022: total agency costs for Nova Scotia Department of Health

Other media articles were found but data not used due to overlap with other data sources.

Provincial nurses union

Nova Scotia Nurses' Union shared data from Nova Scotia Seniors and Long-Term Care (2022, 2023), which was also publicly available.

- 2021–2022 to 2022–2023: total agency costs for seniors and LTC (RN, LPN, personal support worker); factors affecting hourly agency rates

CNE surveys

One health authority reported that they did not use agencies.

Summary of results

agencies: 16 agencies working in province based on media articles and surveys

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)

- 2018 — 22 RNs, 23 LPNs
- 2019 — 25 RNs, 24 LPNs
- 2020 — 18 RNs, 22 LPNs
- 2021 — 20 RNs, 27 LPNs
- 2022 — 25 RNs, 31 LPNs

nurses from agencies in province based on media article

- 2020–2021 to 2022–2023 — not available
- 2023–2024 — >350

nurses from agencies for 1 health authority: 0

Nova Scotia Health

- # agencies
  - 2020-2022 — not available
  - 2022-2023 — 8 agencies
  - 2023-2024 — not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2021-2022 — 6M
  - 2022-2023 — 26.2M April to February
  - Data for remaining years not available
- Total agency hours: not available
- Hourly agency rates: not available

Seniors and long-term care

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2021-2022 — 10M
  - 2022-2023 — 35.3M
  - All costs include RN, LPN, and personal support worker
  - Data for remaining years not available
- Total agency hours: not available
- Hourly agency rates
  - 2021-2022
    - RN range: $134.80 to $138.60
    - LPN: $124.80
    - See Appendix J for direct and indirect costs

Nova Scotia Department of Health

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2020-2021 — 3.1M
  - 2021-2022 — 18.4M
  - 2023-2024 — 126M (unknown time period)
- Total agency hours: not available
- Hourly agency rates: not available

Provincial initiatives

Introduced a policy to limit the use of travel nurses that the following changes will be made to all government contracts for agencies:

1. Travel nurses working for Nova Scotia Health, IWK Health or a government-funded long-term care facility can only be hired for a maximum 180 days.

2. They must wait one year before they can be assigned to work as a travel nurse for these institutions again. They may choose to take a permanent assignment in Nova Scotia or continue to work as a travel nurse in another province.

3. Nurses graduating from post-secondary institutions in Nova Scotia cannot work as travel nurses in the province for one year following graduation.

Prince Edward Island

Data sources used in report

Media articles
Ross (2023)

- 2021-2022: hourly agency rates in province

Other media articles were found but data not used due to overlap with other data sources.

ATIP/FOI request — Health PEI (2024)

- 2020-2021 to 2023-2024: total agency costs, hourly agency rates, factors affecting hourly agency rates
- 2022-2023 to 2023-2024: frequently used practice areas; number of nurses from agencies
- 2023-2024: names/number of agencies used

Summary of results

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)

- No data available for RNs
- 2018 — 5 LPNs
- 2019 — no data available for LPNs
- 2020 — 0 LPNs
- 2021 — 1 to 4 LPNs
- 2022 — 0 LPNs

Health PEI

- # agencies
  - 2020-2023 — not available
  - 2023-2024 — 6 agencies.
- # nurses from agencies
  - 2020 to 2022 — not available
  - 2022-2023 — 19 RNs
  - 2023-2024 — 78 to 125 RNs and 8 LPNs (3 quarters)
- Total costs of agencies
  - 2020-2021 — 27,942
  - 2021-2022 — 0.7M
  - 2022-2023 — 1.4M

    - 2023–2024 — 8.8M forecasted
- Total agency hours: not available
- Hourly agency rates
    - 2021–2022 — $100/hr
    - 2023–2024
        - RN1 average: $113.93, range: $77.80–$170
        - RN2 average: $117.35, range: $77.80–$150
        - LPN average: $86.17, range: $42.87–$120
        - See Appendix J for direct and indirect costs

Provincial initiatives — none found

Newfoundland and Labrador

Data sources used in report

Media articles

1. Barter (2024c)
    - 2023–2024: total agency costs for province
2. Ha (2024b)
    - 2023–2024: hourly agency rates, factors affecting hourly agency rates for province
3. Ha et al. (2024)
    - 2023–2024: hourly agency rates, factors affecting hourly agency rates for province, names of agencies used
4. MacEachern (2023)
    - 2018–2019: total agency costs for province
    - 2022–2023: total agency costs for province
5. Quinn (2024)
    - 2023–2024: number of nurses from agencies

Several other media articles were found but data not used due to overlap with other data sources.

Summary of results

agencies: 12 agencies working in province based on media articles and surveys

agencies in 4 health authorities
- 2020–2023 — not available
- 2023–2024 — 4 agencies

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)
- 2018 — 15 RNs, 16 LPNs
- 2019 — 16 RNs, 16 LPNs
- 2020 — 15 RNs, 18 LPNs

- 2021 — 19 RNs, 23 LPNs
- 2022 — 21 RNs, 28 LPNs

Nurses from agencies in province based on media article:
- 2020-2021 to 2022-2023 — not available
- 2023-2024 — 373 to 357

Newfoundland and Labrador's regional health authorities
- Total costs of agencies
  - 2018-2019 — 1M
  - 2022-2023 — 100M
  - 2023-2024 — 104M estimated
  - Data for remaining years not available
- Total agency hours: not available
- Hourly agency rates
  - 2023-2024
    - Western region (1 agency) general RN: $283.63, specialty RN: $312.35
    - Central region (2 agencies) RN: $145-172.22
    - Eastern region (1 agency) RN: $120-159.50
    - N.L. Eastern, Central, Western, Labrador regions (1 agency): $120; NP — $235
    - See Appendix J for direct and indirect costs

Provincial initiatives
1. March 2024: Auditor General announced they will investigate contracts between private vendors and the province's health sector by conducting a performance audit, to assess how programs are managed and focus on their costs, efficiency and effectiveness.

2. February 2024: Health Minister asked province's Comptroller General, who has oversight of the province's finances, to review Canadian Health Lab's contracts.

3. Nursing locum pilot program: launched in September 2022, the Nurse Locum Program allowed nurses already in the provincial system to fill short-term gaps in Northern remote Labrador for at least two-week blocks.

Yukon

Data sources used in report

CNE survey
- 2020-2021 to 2023-2024: total agency costs and number of nurses from agencies for Yukon Health and Social Services
- 2023-2024: hourly agency rates; factors affecting hourly agency rates; frequently used practice areas; names/number of agencies used

Summary of results

agencies: 5 agencies working in territory based on media article

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)

- No data available for LPNs
- 2018 — 1 to 4 RNs
- 2019 — 1 to 4 RNs
- 2020 — 1 to 4 RNs
- 2021 — 1 to 4 RNs
- 2022 — 7 RNs

Yukon Health and Social Services

- # agencies
  - 2020-2021 — 3 agencies
  - 2021-2022 — 3 agencies
  - 2022-2023 — 3 agencies
  - 2023-2024 — 5 agencies
- # nurses from agencies
  - 2020-2021 — 12 RNs
  - 2021-2022 — 12 RNs
  - 2022-2023 — 24 RNs
  - 2023-2024 — 6 RNs (3 quarters)
- Total costs of agencies
  - 2020-2021 — 1.5M
  - 2021-2022 — 1M
  - 2022-2023 — 1.4M
  - 2023-2024 — 1.6M estimated
- Total agency hours: not available
- Hourly agency costs
  - 2023-2024
    - RN average: $113, RN range: $97-$129
  - See Appendix J for direct and indirect costs

Territorial initiatives — none found

Northwest Territories

Data sources used in report

Media articles

Carroll (2024)

- 2023-2024: hourly agency rates, factors affecting hourly agency rates, names/number of agencies used by Northwest Territories Health and Social Services Authority

Northwest Territories Legislative Assembly (2024)

- 2021-2022 to 2023-2024: total agency costs, factors affecting hourly agency rates for Northwest Territories Health and Social Services Authority, Hay River Health and Social Services Authority and Tłı̨chǫ Community Services Agency

Summary of results

agencies: 6 agencies working in territory based on media article

nurses reporting nursing agencies as primary workplace on annual registration (CIHI data)

- No data available for LPNs
- 2018 — 5 RNs
- 2019 — 1 to 4 RNs
- 2020 — 7 RNs
- 2021 — 12 RNs
- 2022 — 11 RNs
- Numbers also include Nunavut

The Government of Northwest Territories recently reported that agencies cost more than $5M in 2022-2023 and a little over $4M in 2023-2024 with travel expenses and per diems alone accounting for more than $1M and accommodations accounting for an additional $1M in agency spending over the past two years.

Northwest Territories Health and Social Services Authority

- # agencies
  - 2020-2023 — not available
  - 2023-2024 — 6 agencies
- # nurses from agencies: not available
- Total costs of agencies
  - 2021-2022 — 0.5M
  - 2022-2023 — 5.3M
  - 2023-2024 — 4.2M (time period unknown)
- Total agency hours: not available
- Hourly agency costs
  - 2023-2024
    - Average: $125, range: $105-$164; entry level: $98-$101, specialty: $102-$105
    - See Appendix J for direct and indirect costs

Hay River Health and Social Services Authority

- # agencies: not available
- # nurses from agencies: not available
- Total costs of agencies
  - 2021-2022 — 15,831
  - 2023-2024 — 0.2M estimated (time period unknown)
  - Data for remaining years not available
- Total agency hours: not available
- Hourly agency costs: not available

Tłı̨chǫ Community Services Agency

- # agencies: not available
- # nurses from agencies: not available

- Total costs of agencies
  - 2023-2024 — 18,331 (time period unknown)
- Total agency hours: not available
- Hourly agency costs: not available

Territorial initiatives

1. Discussion about re-establishing a working group between the Government of Northwest Territories and union to identify when agency nurses should be used — and when they shouldn't.

2. The government has also been asked by the union to provide "an identifier for each agency nurse that allows the union to monitor such usage while preserving the employer's obligations regarding the disclosure of confidential information".

Nunavut

Data sources used in report

Surveys with nurses working for agencies: names of agencies

Summary of results

- # agencies: 3 agencies based on surveys with nurses working for agencies
- # nurses from agencies: not available
- Total costs of agencies: not available
- Total agency hours: not available
- Hourly agency costs: not available

Territorial initiatives — none found

Federal

Data sources used in report

CNE survey

- 2020-2021 to 2023-2024: total agency costs and total agency hours by RN, LPN and NP
- 2023-2024: factors affecting hourly agency rates, names/number of agencies used

CanadaBuys: Federal contracting information (Government of Canada, 2024a)

- Website lists up-to-date information from active, expired and cancelled tender notices by federal organization
- 2019 to 2024: 130 contracts with agencies listed, including total cost of agency contract (website starts in 2009 but only the last 5 years included in report)

Summary of results

agencies: 13 agencies working for federal organizations across Canada based on CanadaBuys website and survey

Total costs: 130 contracts with 12 agencies totalling more than $3.2B between 2019 and 2024

One federal organization

- # agencies
  - 2020-2021 — 6 agencies
  - 2021-2022 — 4 agencies
  - 2022-2023 — 5 agencies
  - 2023-2024 — 5 agencies
- # nurses from agencies: not available
- Total costs of agencies
  - 2020-2021 — 58.9M
  - 2021-2022 — 73.8M
  - 2022-2023 — 51.5M
  - 2023-2024 — 26M estimated
- Total agency hours
  - 2020-2021 — 420,347
  - 2021-2022 — 495,450
  - 2022-2023 — 333,167
  - 2023-2024 — 159,516 estimated
- Hourly agency costs: cannot disclose any information pertaining to rates in order to safeguard third-party information (See Appendix I for direct and indirect costs)

Federal initiatives — none found

Appendix B: List of agencies provided across Canada

Agencies in this list and the provinces/territories where they provide services were identified based on the CNE surveys, ATIP/FOI requests, provincial nursing unions, surveys completed by nurses who work with agencies, and media articles.

* Only some agencies have been included in the table for Quebec.

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
1	911 Nurses GTA	√	√		√	√		√	√		√				
2	A1 Healthcare Services				√						√				
3	A Supreme Nursing and Home Care Services					√									
4	Access Healthcare	√	√												
5	Activecare Workforce Services Inc.				√										
6	Adapt Healthcare							√							
7	Advanced Home Care Solutions Inc.	√													
8	Agence SPI						√	√							
9	Alivia Medical Inc.					√									
10	All Care Nursing & Health Services					√									

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
11	Allegiance Health Services Corp.				√										
12	Alliance Health Care Staffing Services Inc.				√			√							
13	Altitude Healthcare Staffing Solutions Inc.				√										
14	Amadeus Health Solutions Inc.				√										
15	AMN Healthcare	√				√									
16	Anson CareGivers Inc.					√									
17	Apollo Staffing Solutions Inc.	√			√										
18	Aspire Healthcare Solutions Inc.		√		√										
19	Athabasca Workforce Solution Inc.		√			√									
20	Augury Healthcare		√			√		√							
21	Aureus Medical				√										
22	Aurora Staffing Solutions				√										
23	Aya Healthcare		√		√	√									
24	Bayshore Home Health/HealthCare Ltd.	√	√	√	√	√	√	√	√			√			√
25	Big Hearts Home Healthcare Services Inc.														√
26	Bizcare Group Inc.				√										
27	Blessed Heart Staffing		√						√						
28	Brylu Staffing		√												
29	Calian Ltd.	√	√		√	√			√		√	√			√

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
30	Canadian Health Care Agency Ltd.		√			√									√
31	Canadian Health Labs (9059822 Canada Inc.)	√	√		√	√		√	√		√	√			
32	Care24 Inc.					√									
33	Care Canada Staffing Consultants Inc.					√									
34	Carecor Health Services	√	√		√	√		√	√	√	√				
35	Carelink Home Care Inc.										√				
36	CarePartners					√									
37	Centre Line Agency Ltd.		√		√	√									
38	CH Health & Home Care Services Inc.	√			√										
39	Cherish Health Services				√										
40	Closing the Gap Healthcare					√									
41	CNS Medical Inc.	√	√			√									
42	Co-Care Health Group Inc.				√										
43	Code Staffing Solutions					√									
44	Comcare Healthcare Staffing/Health Services					√									
45	Comfy Care Haven					√									
46	CPR Healthcare Staffing Inc.				√										
47	Creator Healthcare					√									
48	Cross Country Healthcare					√			√						

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
49	Curaga					√									
50	Dawn of Angels Health Inc.					√									
51	Direct Access Staffing Agency Ltd.				√										
52	Dispatch Staffing	√				√									
53	Divine Home Care				√										
54	DLD Healthcare Inc.		√		√	√									
55	Drake Medox				√	√									
56	Dynamic Care Limited		√			√									
57	E.D.G.E. Healthcare Services				√										
58	Elite Intellicare Staffing	√	√	√	√				√		√				
59	Elite Nursing & Home Healthcare				√	√	√								
60	Empire Healthcare Staffing Inc.				√										
61	Endeavour Personnel (EPL Staffing)					√									
62	Esmar Nursing & Community Care			√											
63	Evergreen Nursing Services/Care Agency	√													
64	Executive Nursing and Health Care Inc.				√	√									√
65	Express Employment Professionals	√	√			√									
66	Express Travel Nurse Inc.	√													
67	Ezcare Nursing Agency			√		√				√					

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
68	Fastaff Travel Nursing	√			√										
69	FirstCare Solutions Inc.	√			√	√									
70	First Health Care	√													
71	FirstMed Staffing					√									
72	Flo Medical Staffing Inc.	√				√									
73	Forefront Staffing Resources Inc.	√			√										
74	GEM Healthcare Services		√												
75	Gen 3 Nursing Inc.				√										
76	Gifted Hands Health Services Inc. Diversified				√	√									
77	Gilas Health Care Services Inc.		√		√										
78	Gold Standard Healthcare Ltd.				√	√		√							
79	Goodwill Staffing and Recruitment	√	√	√	√	√		√		√	√		√		
80	Gracious Home Healthcare					√									
81	Gratitude Health (also 5010675 Ontario Ltd.)			√											
82	Greenstaff Medical — Canada	√	√		√	√			√						
83	Hand of Grace Healthcare Staffing	√													
84	Happy Nursing Services (2013) Inc.				√	√									
85	HCP Diagnostics Inc.				√										
86	Health 101 Services Corporation				√										

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
87	HealthOPM Staffing and Recruitment Agency				√	√									
88	Health Staffing International	√													
89	Help Nursing Agency Inc.	√													
90	Helping Hands Healthcare	√				√					√				
91	Hero Care					√									
92	Hines Health Services	√													
93	HSEL Nursing Care Corporation				√										
94	I-Ace It Healthcare Staffing Solutions		√		√										
95	Indemand Care Healthcare Services														
96	In-Home Personal Care				√										
97	lntegriCare United Staffing Solutions Inc.				√										
98	Integrity Health Care Services				√										
99	Interior HomeCare Solutions	√													
100	JTC Staffing Solutions				√										
101	Just Like Family Home Care				√										
102	Legacy Care Inc.				√										
103	Life Line Healthcare			√	√										
104	Livingwaters Healthcare Inc.		√												
105	Lovely Heart Nursing Agency			√											

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
106	Lucky Health and Home Care Staffing Services				√										
107	Magnus Staffing					√	√	√							
108	Maple Home Care								√						
109	Maple Tree Employment Solution Services							√							
110	Mara Home & Health Services				√										
111	Mas Medical Staffing		√												
112	Matrix Force Universal Sante Ltd.				√										
113	McCare Global Healthcare Services Inc.	√		√	√									√	√
114	Medsag Inc.					√									
115	Mikisew-International SOS Limited Partnership, International SOS														√
116	Millionhands Staffing Solutions Inc.					√									
117	Mimak Care Corporation					√									
118	Morning Breeze Healthcare				√										
119	Multi Options Nursing Inc. (MON+)						√	√							√
120	New Horizons Staffing Inc.		√	√	√	√		√							
121	New Star Healthcare Staffing Inc.				√										
122	Nexim HealthCare Consultants Inc.				√	√									
123	NHI Nursing & Homemakers Inc.				√	√									

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
124	Nightingale Health Services Ltd.				√										
125	Nipissing Healthcare					√									
126	Northern Medical Connections	√	√		√	√			√	√	√				
127	Northern Nursing Solutions Inc.	√	√			√			√						
128	Northern Wellness Group					√									
129	Nurse Next Door	√	√		√	√			√						
130	Nurse Relief Inc.	√	√	√				√							
131	NurseX Corporation				√	√									
132	OnCall Nursing Services	√													
133	ONZ Kare Corp.							√							
134	Optimum Care	√													
135	Origin Travel Nurses		√												
136	Oxford Staffing Solutions	√													
137	Pals Staffing Services Inc.		√												
138	Paramed Home Health Care		√		√	√									
139	Paramount Care Nursing Agency					√									
140	People 2.0 Workforce Solutions (formerly The Staffing Edge)					√		√							
141	Plan A	√			√	√		√							

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
142	Premier Soin Nordik Inc./Premier Health Nordik Inc.						√	√							√
143	Prescare Nursing and Healthcare Staffing	√			√										
144	Prime Holistic Care				√										
145	Priority Healthcare Staffing	√	√			√		√							
146	Progressive Staffing Solutions					√									
147	Promed HR Solutions Inc.	√													
148	Pulse Health Care Ltd.				√										
149	Qualicare	√	√												
150	Quantum Staffing					√									
151	Quick Care Ltd.	√			√										
152	R2K Healthcare Services Ltd.				√										
153	Red Poppy Nursing and Home Healthcare Services Inc.				√										
154	Reid Staffing Services				√										
155	Reliable Care Health Services				√	√									
156	Relief Care Inc.				√										
157	Resource Ability & Nursing Solutions	√													
158	Revolve Staffing Ltd.	√				√									

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
159	Right at Home					√									
160	Sahara Staffing Solutions	√	√												
161	Saltgrass Health	√													
162	Savior Healthcare Staffing Provider				√										
163	SD&G Med Staff					√									
164	SE Health		√			√									
165	Select Medical Connections Ltd.	√	√	√	√	√	√	√	√		√	√		√	
166	Serene Care									√					
167	Simple Staffing Inc.	√		√											
168	Skyline Nursing Inc.				√		√								
169	Solutions Nursing L.F.C.														√
170	Solutions Staffing Inc. (includes TravelNurse)	√	√	√	√	√		√	√	√	√		√		√
171	Source Medical			√											
172	S.R.T. Med Staff					√									
173	Staff Relief Health Care Services Inc.	√				√									
174	Staffing Solutions	√	√		√	√									
175	Staffy	√	√			√									
176	Superdoc Consulting Inc.	√													
177	Superior Care Health Inc.		√		√										

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
178	Supplemental Health Care				√										
179	Sympatico Medical Solutions Inc.	√	√			√									
180	Teal Recruitment		√		√	√		√							
181	The Care Company		√												
182	The Expert Care — Health Staffing Solutions				√										
183	TLC Alert Nursing & Home Care Services				√	√									
184	Trained Outstanding Professional (T.O.P.) Healthcare Solutions Inc.				√										
185	Transcend Healthcare Staffing Solutions				√										
186	Trillium Med Village					√		√							
187	Triple E Healthcare and Nursing Services Inc.				√										
188	True Care Alliance Staffing Inc.			√	√										
189	Trusted Health				√										
190	UND Healthcare Services					√									
191	United Med Staffing Inc.					√									
192	Unity Healthcare Solutions Inc.				√	√	√	√							
193	Venture Healthcare Inc.	√	√	√	√	√						√		√	√
194	Victorian Order of Nurses (VON)	√	√			√			√						√
195	Vision Health Services Ltd.		√		√										

#	Name of agency	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Quebec*	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Yukon	Northwest Territories	Nunavut	Federal
196	Voyagecare Health Services	√			√										
197	We Care4U					√		√							
198	We Care Home Health Services					√									

Listed below are an additional 274 agencies identified in the surveys completed by six health authorities in Quebec.

24/7 Expertise de Soins de Santé Inc.
2S Agence de Placement Inc.
7J Inc.
9053-9776 Québec Inc. / L'agence Services Santé
9248-1019 Québec Inc. Agence Marie Flore
9358-2443 Québec Inc. / Services Jobillus Plus
9381-8797 Québec Inc. /Soins santé plus
9386-6374 Québec Inc. / Emergence Santé
9400-9487 Québec Inc. / MTC Soins Infir.
9402-9295 Québec Inc. / SOS Soins
9405-3600 Québec Inc. / Roal Santé
9413-0986 Québec Inc. / Services SFT
9428-3751 Québec Inc.
9435-4933 Québec Inc. / ASC Medic
9439-3428 Québec Inc. / Flash Selection
9449-3723 Québec Inc. / Caring 24/7
9451-2001 Québec Inc.
9452-6944 Québec Inc / Agence MY
9453-3643 Québec Inc. / DNM Médic
9456-8763 Québec Inc.
9457-3946 Québec Inc./ Agence MPO
9458-8803 Québec Inc.
9459-5998 Québec Inc/ Telisma Wesly
9460-3065 Québec Inc. / H.E Papette
9462-3279 Québec Inc.
9464-8300 Québec Inc./ Agence Premier recours
9466-6401 Québec Inc. / Prom Agence de placement
9466-6799 Québec Inc. / Saucar Santé
9466-7730 Québec Inc. / Likibi-Kwa Santé
9468-3216 Québec Inc. / MF Ressources Inc.
9468-5302 Québec Inc. /AMC Recrutement
9470-5498 Québec Inc. / Agence Santé Prio
9471-1363 Québec Inc. / Oli Santé
9471-8350 Québec Inc. / Service Santé Béa
9472-3319 Québec Inc. / Groupe MMD Services
9478-1614 Québec Inc.
9480-6114 Québec Inc. / Ressources Express Santé
9482-6146 Québec Inc. / Phoenix Kanata
À Vos Soins Santé / 12014408 Canada Inc.
Accent Soins
Acte Santé Inc.
Action Santé LC (9162-5327 Québec Inc.)
AD Services de placement Inc.
AE Primo Santé Inc.
Agence Altitude Medic. Inc.
Agence ASST / Accord en Soins de Santé et Traitement
Agence Continuum Inc.
Agence Cothia Inc.
Agence De Personnel Novasol. Med Inc.
Agence de Placement Bonheur / Ressource Intermediaire Eben-Ezer Inc.
Agence de Placement Del-Wend-D international Inc.
Agence de Placement Distinction
Agence de Placement Excelflex / 13260534 Canada Inc.
Agence de Placement Hall Anterson LUC
Agence de Placement Medi-Tech
Agence de Placement Ruster
Agence de Recrutement et placement Avantages Plus Inc.
Agence de Santé Gefred /12296969 Canada Inc.
Agence de Soins HB
Agence Diane Albert Inc.
Agence DND Placement Inc.
Agence Elie Inc.
Agence Facile Emploi Inc.
Agence Felix
Agence Go Santé Inc.
Agence Groupe Prosanté
Agence la Famille
Agence M.D. Santé Inc.
Agence Multiservices 5 Étoiles Inc.
Agence Nomade Inc.
Agence Sanitas Inc.
Agence Santé Harmonie Inc.
Agence SA Santé NTE OR Plus Inc.
Agence Soins et Santé
Agence Solution Santé

Agence Solutions RH
Agence Viva Medic Inc.
Aidexpresse Inc.
Aleat Santé
Alpha Omega Solutions Travail Inc.
Alternative-medic Inc.
Amika — Aide et Soins à Domicile Inc.
Appelle-Moi Inc.
Archi-Medic Inc.
Arma Santé
Armagence
ASICC-Med 9002 9323 Québec Inc.
Assistance Santé Plus
AZ Ressources Humaines Inc.
Bassam Emploi Inc.
BCS Longueu Berger Santé IL
Belle Agence Inc.
Bien Chez soi Laurentides / 9421-3055 Québec Inc.
Bien Chez sois Beloeil 9431-3244 Québec Inc.
Biron
Camer Santé
Carnode B. Soins de Santé Inc.
Casone Santé S.A.
Clinique Infirmiere Nord-Ouest Inc.
Clinistat Inc.
Code Bleu Placement en Santé
Collabsanté Inc.
Confort Elite / Garde confort (Vitale)
Damejo Inc.
Damycare Inc.
Danato Soins Inc.
Dix-Trente
Domaine Soins Santé Inc.
Eden Confort Inc.
Elvision Santé $ Services Inc.
Elyon Placement Inc.
Embauche Solution RH
Emily Expert Inc.
Esca Santé
Espoirsanté Inc.
Étoile de la Santé / 12970601 Canada Inc.
Expert Medic SST
Firme Brouillette Inc.
Forstaff Placement
Fortune Santé
Gardemédic / 9424-5636 Québec Inc.
Genesis Santé Groupe Inc.
Gestion LS Bedard Inc.
GK Action Santé
Grad Agence de Personnel Inc.
Groupe ADR Inc.
Groupe AMS
Groupe Aspis Inc.
Groupe DJ Santé
Groupe EM
Groupe FCJR Inc.
Groupe Harfang Santé Inc.
Groupe OptiNursing Inc.
Groupe Repère Expertise Inc.
Groupe Santé IPA Inc.
Groupe Santé MF
Groupe Serenis Inc.
Groupe SM
Groupe Synappo Inc.
Groupe Udson Inc.
Groupe Unit Inc.
Hello Santé Inc.
Helse Group Inc.
Horizon Santé Plus Inc.
Impro Santé Inc.
IMQ
Infirmiers Mobiles
Intégrité service Inc.
Jamoda Services Inc.
Jane Kelly Inc.
Jiskobou Inc.
JR santé Inc.
Kerniel Santé
KMS Solution Inc.
Lemo-Santé Inc.
Les Services Infirmiers Novo-Soins
L'etoile à Domicile Inc.
L'étoile Montante Inc.
Loire du Printemps, pur Intérieur Inc.
M.F.C Soins de Santé
MAG Services / Mac Arthy Genius

MAP Santé Inc.
Marvino-Services
Medialpha
Medic Connexion
Medic Sans Limit
Médic-excel Inc.
MICD.Santé Inc.
MIFI
MIL Placement
MJS Services de Santé
Montréal Famillisoins Inc.
Mozart Placement Inc.
MSL
Multi Ressources Yotta Inc.
Multi-Ressources Connexion Inc.
Multisolutions Santé Inc.
N2K Médic Inc.
Naissemon Flan Santé Inc.
NBL Services-Santé Inc.
Nissi Ressources
Nutri
Oasis Santé F.M. Inc.
P.E. Santé Inc.
Patron Inc.
PE Santé
Performe Santé Inc.
Personnel Expert Inc.
Phoenix Soins Santé Inc.
Placement AltaMédic Inc.
Placement Ange Gardiens Inc.
Placement Guijo Inc.
Placement JM Santé Inc.
Placement Mieux-être (Lucalberte Santé)
Placement RCR Inc.
Placement RH Quevillon
Placement Santé Prestige Inc.
Placement Zoé Inc.
Placements Pro ETI Inc.
Premium Healthcare Providers
Pro axe Santé Inc.
Pro Santé
Providence Santé Inc.
Quatre M
Recours Santé
Recrutement Elegance Inc.
Recrutement Élixir
Recrutement Groupe S.M. Inc.
Resolu-Soins Inc.
Ressources Santé Lachance Inc. / Medic-OR
Ressources Santé LM Inc.
RMS Prosanté Inc.
RS Placement / 9434-6798 Québec Inc.
Sanned Inc.
Santé Excellence Plus S.E.N.C
Santé Majenic Inc.
Santé Placement
Satellite Santé
Secours Santé
Séphora Santé Inc.
Service de Santé Alternacare
Service Santé Mukadienne Inc.
Servicegem Inc.
Services Groupe Action Inc.
Services Infirmiers Pro-Soins Inc.
Services Professionnels — Infirmier Inc.
Services Progressifs Placement en Soins de Santé Inc.
Services Soins Infirmiers Marie Michèle Inc.
Servir + Soins et Soutien à Domicile Inc.
Shelsa Placement Inc.
SHK Santé Inc.
SHL Référence
Simo Soins de Sante Inc.
Societe Bee Refer
Soins 123 GO! Inc.
Soins 2A Inc.
Soins Avicenne
Soins de Santé le Fleuron Inc.
Soins et Assistance FAB Inc.
Soins Expert Plus
Soins Infirmiers Plus (SIP)
Soins Intermediaire Inc.
Soins Med Inc.
Soins Maid
Soins Nadi
Soins Nursia Inc.
Soins Plus

Soins Précieux Inc.
Soins Rymed Inc.
Soins SK Santé Inc.
Solu Med Inc.
Solution Ayibotek Inc.
Solution Recrutements et Soins Inc.
Solutions LDS Inc.
Source de Vie / Services de Santé Inc.
Star Santé / 9464-6221 Québec Inc.
Steen Soins-Pro
Succès Mel Santé Inc.
Supexel Inc.
Supportsanté Inc.
Symphonie Santé Inc.
Synergie Hunt International — Québec
T-Concept Synergik Inc.
Trait-d'union Santé
Vaisseau Santé Inc.
Vemaro Agence de Placement Inc.
Vision Avenir Groupe Inc.
VL Soins, Recherche et Consultation Inc.
VQ Sept

Appendix C: Detailed overview of total cost of agencies by jurisdiction during past six fiscal years using available data

Data source	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023	2023–2024 (Q1–Q3 mostly)	2023–2024 projection (based on previous column)
British Columbia							
All health authorities (hospitals, care homes and other public facilities) (Daflos, 2024a; 2024b)	–	–	–	$76.7M	$163M	–	–
Provincial Health Services Authority (Barter, 2024a)	–	–	–	–	–	$1.1 M (Sept–Mar)	$1.9M
Vancouver Costal Health (2024b)	$4.2M	$6M	$4.6M	$6.1M	$24.1M	$22.8M (Apr–Jan)	$27.4M
Fraser Health Authority (2024; Daflos, 2022; 2024a; 2024b)	$3M	$2M	$4.7M	$11.8M	$ 14.7M	$11.2M (Apr–Jan)	$13.4M
Interior Health (Daflos, 2022; 2024a; 2024b)	$1M	$2M	$1.3M	$8.5M	$34.4M	–	–

Data source	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-Q3 mostly)	2023-2024 projection (based on previous column)
Northern Health (Daflos, 2022; 2024a; 2024b)	$4.6M	$8.60	$12.60	$27.2M	$52M	-	-
Vancouver Island Health (Daflos, 2022; 2024a; 2024b)	$0	$0	$5.7M	$20.1M	$37.5M	-	-
Alberta							
Alberta Health Services (French, 2023)	$0.4M	$2.7M	$5M	$5.1 M	-	-	-
Covenant Health (French, 2023)	-	-	-	$0.3M	$2.2M (Q1-Q3 only)	-	-
Saskatchewan							
Saskatchewan Health Authority (Saskatchewan Union of Nurses (SUN), 2023; 2024; Prisciak, 2024)	-	-	$1.4M (3 agencies only)	$12.3M (2021 calendar year)	$45.3M (2022 calendar year)	$59.2M (2023 calendar year)	-
Manitoba							
Shared Health (Manitoba Nurses Union (MNU), 2024)	-	-	$63,330	$8,923	-	-	-

Data source	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-Q3 mostly)	2023-2024 projection (based on previous column)
Winnipeg Regional Health Authority (MNU, 2024)	$454,102	$3.8M	$2.6M	$4.1M	$4.1M	-	-
Prairie Mountain Health (2024; MNU, 2024)	$7.8M	$9.9M	$14M RN worked/travel time: $4.3M LPN worked/travel: $6.9M RN/LPN/health care aide mileage/ accommodation: $2.8M	$28M RN worked/travel time: $8.9M LPN worked/travel time: $12.4M RN/LPN/health care aide mileage/ accommodation: $6.7M	$23.1M RN Worked: $8.2M Travel time: $2.7M Mileage/ accommodation: $3.1M LPN Worked: $4.8 M Travel time: $1.8 M Mileage/ accommodation: $2.5 M	$16.9M (Apr-Dec) RN Worked: $6.2M Travel time: $2.2M Mileage/ accommodation: $2.5M LPN Worked: $3M Travel time: $1.3M Mileage/ accommodation: $1.7M	$22.5M
Southern Health-Santé Sud (2024; MNU, 2024)	$1.50	$2.1M	$2.1M RN: $1.4M LPN: $0.7M	$5.6M RN: $3.4M LPN: $2.2M	$8.1M	$5.8M (Apr-Nov) RN: $3.8M LPN: $2M	$8.7M

Data source	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-Q3 mostly)	2023-2024 projection (based on previous column)
Northern Health Region (2024; MNU, 2024)	$3.1M	$4M	$8M RN Worked: $5.3M Travel and other expenses: $2.1M LPN Worked: $0.6M Travel and other expenses: $60,173	$10.4M	$12.9M RN Worked: $6.4M Travel and other expenses: $4.8M RPN Worked: $12,178 Travel and other expenses: $590 LPN Worked: $1.4 M Travel and other expenses: $0.3M	$10.8M (Apr-Dec) RN Worked: $5M Travel and other expenses: $4.2M LPN Worked: $1.1M Travel and other expenses: $0.5M	$14.4M
Interlake-Eastern Regional Health Authority (2024; MNU, 2024)	$3.7M	$4.3M	$6.7M RN: $5M LPN: $1.7M	$7.7M RN: $5.8M LPN: $1.9M	$11.5M RN: $8M LPN: $3.5M	$9.8M (Apr-Nov) RN: $7.1M LPN: $2.7M	$14.7M
Ontario							
Ontario hospitals and long-term care homes (Jones, 2024)	-	-	-	$368.6M	$600.2M (projected)	-	-
Ontario long-term care homes (AdvantAge Ontario, 2022)	-	-	-	-	~ $6M/month (100 homes)	-	-

Data source	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-Q3 mostly)	2023-2024 projection (based on previous column)
Ontario Hospitals (Ontario Nurses' Association (ONA), 2023)	-	-	$38.1M	$68.4M	$154M (Q1-Q3 most often)	-	-
Ontario Hospital 1 survey	-	-	$0	$0.1M	$57,600	$0	-
Ontario Hospital 2 survey	-	-	$0	$0	$0.2M (all RN)	$0.6M (Apr-Dec) RN: $0.5M LPN: $93,118	$0.8M
Ontario Hospital 3 survey	-	-	$0	$0	$1 M RN: $0.9M LPN: $0.1M	$1.1M (Apr-Dec) RN: $1M LPN: $0.1M	$1.5M
Ontario Hospital 4 survey	-	-	$0	$1.2M RN: $0.8M LPN: $0.4M	$2.6M RN: $1.7M LPN: $1M	$3.4M (Apr-Dec) RN: $1.8M LPN: $1.6M	$4.5M
Quebec							
Province (Authier, 2023; Grant & Ha, 2024)	2016-2023: $3 billion (all agency staff)			-	$578M	-	-
Health Authority 1 survey	-	-	$0.2M RN: $0.2M	$0.3M RN: $0.3M LPN: $2,596	$1.2M RN: $1.2M	$0.8M (Apr-Dec) RN: $0.8M	$1.1M
Health Authority 2 survey	-	-	$15.8M RN: $12M LPN: $3.8M	$36M RN: $24.5M LPN: $11.5M	$54.8M RN: $42M LPN: $12.8M	$43.2M (Apr-Dec) RN: $34.6M LPN: $8.6M	$57.6M

Data source	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-Q3 mostly)	2023-2024 projection (based on previous column)
Health Authority 3 survey	-	-	-	$3.1M RN: $2.6M LPN: $0.5M	-	$26.3M (Apr-Dec) RN: $18.7M LPN: $7.6M	$35.1M
Health Authority 4 survey	-	-	$6.8M RN: $5.6M LPN: $1.2M	$6.3M RN: $4.9M LPN: $1.4M	$9M RN: $7M LPN: $2M	$22.2M (Apr-Dec) RN: $17M LPN: $5.2M	$29.6M
Health Authority 5 survey	-	-	$13M RN: $8.7M LPN: $4.3M	$24.7M RN: 17.3M LPN: $7.4M	$27.8M RN: $20.1M LPN: $7.7M	$47M (Apr-Dec) RN: $32M LPN: $15M	$62.7M
Health Authority 6 survey	-	-	$41.7M RN: $28.2M LPN: $13.5M	$36.6 M RN: $25.9M LPN: $10.7M	$39M RN: $29M LPN: $10M	$68M (Apr-Dec) RN: $53.7M LPN: $14.3M	$90.7M
New Brunswick							
Vitalité Health Network (Barter, 2024b; CBC News, 2023)	-	-	-	-	$5.9M July-Dec	$68.5M (Sept-Mar)	$117.4M
Vitalité Health Network (Auditor General of New Brunswick, 2024)				$123M on use of contracted health care workers (RN, LPN, personal support workers) Jan 1, 2022 to Feb 29, 2024			

Data source	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-Q3 mostly)	2023-2024 projection (based on previous column)
Horizon Health Network survey *(includes salary, registration fees, travel, accommodations)	-	-	-	-	$5M*	$41.1M* (Apr-Dec)	$54.8*
Horizon Health Network (Auditor General of New Brunswick, 2024)				$48M Jan 1, 2022, and Feb 29, 2024			
Department of Social Development (Auditor General of New Brunswick, 2024)					$2.9M (Feb-July/22)		
Nova Scotia							
Nova Scotia Department of Health (Gorman, 2024; Yarr, 2023)	-	-	$3.1M	$18.4M		$126M (unknown time period)	-
Seniors and long-term care (Nova Scotia Seniors and Long-Term Care, 2023)	-	-	-	$10M (RN, LPN, personal support worker)	$35.3M (RN, LPN, personal support worker)	-	-
Nova Scotia Health (McPhee, 2023)	-	-	-	$6M RN: $5.6 M LPN: $0.4M	$26.2M (Apr-Feb) RN: $25.4M LPN: $0.8M	-	-

Data source	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023	2023–2024 (Q1–Q3 mostly)	2023–2024 projection (based on previous column)
Prince Edward Island							
Health PEI (2024)	-	-	$27,942	$0.7M	$1.4M	$8.8M (forecasted by HPEI)	-
Newfoundland and Labrador							
Newfoundland and Labrador's regional health authorities (Barter, 2024c; MacEachern, 2023)	~ $1 M	-	-	-	~ $100M	$86.7M (Apr–Jan)	$104M
Northwest Territories							
Northwest Territories Health and Social Services system (sum of costs at 3 facilities below)	-	-	-	$0.5M	$5.3M	$4.4M (unknown time period)	-
Northwest Territories Health and Social Services Authority (Northwest Territories Legislative Assembly, 2024)	-	-	-	$0.5M	$5.3M	$4.2M	-

Data source	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-Q3 mostly)	2023-2024 projection (based on previous column)
Hay River Health and Social Services Authority (Northwest Territories Legislative Assembly, 2024)	-	-	-	$15,831	-	$0.2M	-
Tłı̨chǫ Community Services Agency (Northwest Territories Legislative Assembly, 2024)	-	-	-	-	-	$18,331	-
Yukon							
Yukon Health and Social Services Survey	-	-	$1.5M (all RN)	$1M (all RN)	$1.4M (all RN)	$1.3M (all RN) (Apr-Jan)	$1.6M
Federal organization							
Survey from federal organization, provides health care services in Alberta, Manitoba, Ontario, Quebec **Excludes taxes	-	-	$58.9M** RN: $56.2M LPN: $1.9M NP: $0.8M	$73.8M** RN: $68.3M LPN: 3.7M NP: $1.8M	$51.5M** RN: $51.1M LPN: $0.4M	21.7M** (Apr-Jan) RN: $21.7M LPN: $12,343	$26M**

Appendix D: Overview of available data sources used in Figure 2: total cost in Canada during past four fiscal years

Data sources selected to avoid overlap between data. Only the last 4 years were selected to capture the most data. Bolded numbers are the values used in Figure 2.

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-3 mostly)	Additional projection for remainder of 2023-2024
British Columbia					
Sum of health authorities listed below	**$28.9M**	**$73.7M**	**$162.7M**	**$35.10**	**$7.6M**
Provincial Health Services Authority (Barter, 2024a)	n/a	n/a	n/a	$1.1 M (Sept-Mar)	$0.8M (estimate for Apr-Sept)
Vancouver Costal Health (2024b)	$4.6M	$6.1M	$24.1M	$22.8M (Apr-Jan)	$4.6M (estimate for Feb-Mar)
Fraser Health Authority (2024; Daflos, 2022; 2024a; 2024b)	$4.7M	$11.8M	$ 14.7M	$11.2M (Apr-Jan)	$2.2M (estimate for Feb-Mar)
Interior Health (Daflos, 2022; 2024a; 2024b)	$1.3M	$8.5M	$34.4M	n/a	n/a
Northern Health (Daflos, 2022; 2024a; 2024b)	$12.6M	$27.2M	$52M	n/a	n/a

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-3 mostly)	Additional projection for remainder of 2023-2024
Vancouver Island Health (Daflos, 2022; 2024a; 2024b)	$5.7M	$20.1M	$37.5M	n/a	n/a
Alberta					
Sum of health authorities listed below	$5M	$5.4M	$2.2M		
Alberta Health Services (French, 2023)	$5M	$5.1 M	n/a	n/a	n/a
Covenant Health (French, 2023)	n/a	$0.3M	$2.2M (Q1-Q3 only)	n/a	n/a
Saskatchewan					
Saskatchewan Health Authority (Saskatchewan Union of Nurses (SUN), 2023; 2024; Prisciak, 2024)	$1.4M (3 agencies)	$12.3M (2021 calendar year)	$45.3M (2022 calendar year)	$59.2M (2023 calendar year)	2023-2024 data obtained was for full fiscal year
Manitoba					
Sum of health authorities listed below	$33.5M	$55.8M	$59.7M	$43.3M	$17M
Shared Health (Manitoba Nurses Union (MNU), 2024)	$63,330	$8,923	n/a	n/a	n/a
Winnipeg Regional Health Authority (MNU, 2024)	$2.6M	$4.1M	$4.1M	n/a	n/a
Prairie Mountain Health (2024)	$14M	$28 M	$23.1M	$16.9M (Apr-Dec)	$5.6M (estimate for Jan-Mar)
Southern Health-Santé Sud (2024; MNU, 2024)	$2.1M	$5.6M	$8.1M	$5.8M (Apr-Nov)	$2.9M (estimate for Dec-Mar)

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-3 mostly)	Additional projection for remainder of 2023-2024
Northern Health Region (2024; MNU, 2024)	$8M	$10.4M	$12.9M	$10.8M (Apr-Dec)	$3.6M (estimate for Jan-Mar)
Interlake-Eastern Regional Health Authority (2024; MNU, 2024)	$6.7M	$7.7M	$11.5M	$9.8M (Apr-Nov)	$4.9M (estimate for Dec-Mar)
Ontario					
Sum of sources listed below	**$38.1M**	**$368.6M**	**$600.2M**	**$600.2M* (see note)**	n/a
Ontario hospitals and long-term care homes (Jones, 2024)	n/a	$368.6M	$600.2M	n/a	n/a
Ontario hospitals (Ontario Nurses Association (ONA), 2023)	$38.1M	-	-	n/a	n/a
Quebec					
Sum of health authorities listed below	**$77.5M**	**$107M**	**$131.8M**	**$207.5M**	**$69.3M**
Health Authority 1 survey	$0.2M	$0.3M	$1.2M	$0.8M (Apr-Dec)	$0.3M (estimate for Jan-Mar)
Health Authority 2 survey	$15.8M	$36M	$54.8M	$43.2M (Apr-Dec)	$14.4M (estimate for Jan-Mar)
Health Authority 3 survey	n/a	$3.1M	n/a	$26.3M (Apr-Dec)	$8.80 (estimate for Jan-Mar)
Health Authority 4 survey	$6.8M	$6.3M	$9M	$22.2M (Apr-Dec)	$7.4M (estimate for Jan-Mar)

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-3 mostly)	Additional projection for remainder of 2023-2024
Health Authority 5 survey	$13M	$24.7M	$27.8M	$47M (Apr-Dec)	$15.7M (estimate for Jan-Mar)
Health Authority 6 survey	$41.7M	$36.6M	$39M	$68M (Apr-Dec)	$22.7M (estimate for Jan-Mar)
New Brunswick					
Sum of health authorities listed below			**$13.8M**	**$109.6M**	**$62.6M**
Vitalité Health Network (Barter, 2024b; CBC News, 2023)	n/a	n/a	$5.9M (July-Dec)	$68.5M (Sept-Mar)	$48.9M (estimate for Apr-Aug)
Horizon Health Network Survey	n/a	n/a	$5M*	$41.1M* (Apr-Dec)	$13.7M (estimate for Jan-Mar)
Department of Social Development (Auditor General of New Brunswick, 2024)	n/a	n/a	$2.9M (Feb-July/2022)	0	0
Nova Scotia					
Sum of health authorities listed below	**$3.1M**	**$18.4M**	**$61.5M (sum of data below)**	**$126M**	**n/a**
Nova Scotia Department of Health (Gorman, 2024; Yarr, 2023)	$3.1M	$18.4M		$126M (unknown time period)	-
Seniors and long-term care (Nova Scotia Seniors and Long-Term Care, 2023)	-	-	$35.3M	-	-
Nova Scotia Health (McPhee, 2023)	-	-	$26.2M	-	-

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-3 mostly)	Additional projection for remainder of 2023-2024
Prince Edward Island					
Health PEI (2024)	$27,942	$0.7M	$1.4M	$8.8M (forecasted by HPEI)	2023-2024 (data obtained was for full fiscal year)
Newfoundland and Labrador					
Regional health authorities Barter, 2024c; MacEachern, 2023)	-	-	~ $100M	$86.7M (Apr-Jan)	$17.3M (estimate for Feb-Mar
Northwest Territories					
Northwest Territories Health and Social Services system (sum of costs listed below)	n/a	$0.5M	$5.3M	$4.4M (unknown time period)	n/a
Northwest Territories Health and Social Services Authority (NTHSSA) (Northwest Territories Legislative Assembly, 2024)	n/a	$0.5M	$5.3M	$4.2M	n/a
Hay River Health and Social Services Authority (Northwest Territories Legislative Assembly, 2024)	n/a	$15,831	n/a	$0.2M	n/a
Tłįchǫ Community Services Agency (Northwest Territories Legislative Assembly, 2024)	n/a	n/a	n/a	$18,331	n/a
Yukon					
Yukon Health and Social Services Survey	$1.5M	$1M	$1.4M	$1.3M (Apr-Jan)	$0.3M (estimate for Feb-Mar)

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (Q1-3 mostly)	Additional projection for remainder of 2023-2024
Federal organization					
Survey from federal organization (health care services in Alberta, Manitoba, Ontario, Quebec)	$58.9M	$73.8M	$51.5M	21.7M (Apr-Jan)	$4.3M (estimate for Feb-Mar)

*Note: Comparable data not available for Ontario in 2023-2024, therefore cost data from 2022-2023 used
n/a = not available

Appendix E: Overview of available data sources used in Figure 3: total costs across a subset of health care facilities

Data sources selected based on consistently reported data the past four fiscal years.
Bolded numbers are total values used in Figure 3.

	2020–2021	2021–2022	2022–2023	2023–2024 projected
British Columbia				
Sum of health authorities listed below	**$9.3M**	**$17.9M**	**$38.8M**	**$40.8M**
Vancouver Costal Health (2024b)	$4.6M	$6.1M	$24.1M	$27.4M
Fraser Health Authority (2024; Daflos, 2022)	$4.7M	$11.8M	$14.7M	$13.4M
Saskatchewan				
Saskatchewan Health Authority (SUN, 2023; 2024; Prisciak, 2024)	**$1.4M**	**$12.3M**	**$45.3M**	**$59.2M**
Manitoba				
Sum of health authorities listed below	**$30.8M**	**$51.7M**	**$55.6M**	**$60.3M**
Prairie Mountain Health (2024)	$14M	$28M	$23.1M	$22.5M
Southern Health-Santé Sud (2024; MNU, 2024)	$2.1M	$5.6M	$8.1M	$8.7M
Northern Health Region (2024; MNU, 2024)	$8M	$10.4M	$12.9M	$14.4M
Interlake-Eastern Regional Health Authority (2024; MNU, 2024)	$6.7M	$7.7M	$11.5M	$14.7M

	2020-2021	2021-2022	2022-2023	2023-2024 projected
Ontario				
Sum of sources listed below	$0	$1.3M	$3.9M	$6.8M
Ontario Hospital 1 survey	$0	$0.1M	$57,600	-
Ontario Hospital 2 survey	$0	$0	$0.2M	$0.8M
Ontario Hospital 3 survey	$0	$0	$1 M	$1.5M
Ontario Hospital 4 survey	$0	$1.2M	$2.6M	$4.5M
Quebec				
Sum of health authorities listed below	$77.5M	$103.9M	$131.8M	$241.7M
Health Authority 1 survey	$0.2M	$0.3M	$1.2M	$1.1M
Health Authority 2 survey	$15.8M	$36M	$54.8M	$57.6M
Health Authority 4 survey	$6.8M	$6.3M	$9M	$29.6M
Health Authority 5 survey	$13M	$24.7M	$27.8M	$62.7M
Health Authority 6 survey	$41.7M	$36.6M	$39M	$90.7M
Nova Scotia				
Sum of health authorities listed below	$3.1M	$18.4M	$61.5M	$126M
Nova Scotia Department of Health (Gorman, 2024; Yarr, 2023)	$3.1M	$18.4M		$126M
Seniors and LTC (Nova Scotia Seniors and Long-Term Care, 2023)	-	-	$35.3M	
Nova Scotia Health (McPhee, 2023)	-	-	$26.2M	
Prince Edward Island				
Health PEI (2024)	$27,942	$0.7M	$1.4M	$8.8M

	2020–2021	2021–2022	2022–2023	2023–2024 projected
Northwest Territories				
Northwest Territories Health and Social Services system (sum of health authorities listed below)	**-**	**$0.5M**	**$5.3M**	**$4.4M**
Northwest Territories Health and Social Services Authority (NTHSSA) (Northwest Territories Legislative Assembly, 2024)	-	$0.5M	$5.3M	$4.2M
Hay River Health and Social Services Authority (Northwest Territories Legislative Assembly, 2024)	-	$15,831	-	$0.2M
Tłı̨chǫ Community Services Agency (Northwest Territories Legislative Assembly, 2024)	-	-	-	$18,331
Yukon				
Yukon Health and Social Services Survey	**$1.5M**	**$1M**	**$1.4M**	**$1.6M**
Federal organization				
Survey from federal organization	**$58.9M**	**$73.8M**	**$51.5M**	**$26M**

Appendix F: Overview of federal contracts 2019-2024: obtained from CanadaBuys website (Government of Canada, 2024a)

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Department of Indigenous Services (ISC)	2024	McCare Global Healthcare Services Inc.	Health Care	$2.0M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Venture Healthcare Inc.	Health Care	$3.5M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Canadian Healthcare Agency LTD.	Health Care	$0.3M	Alberta	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Premier Health Nordik Inc. (Premier soin Nordik Inc.)	Health Care	$0.08M	Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Venture Healthcare Inc.	Health Care	$0.3M	Alberta	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Mikisew-International SOS Limited Partnership, International SOS Canada	Health Care	$0.3M	Alberta	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Canadian Healthcare Agency LTD.	Health Care	$2.0M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Department of Indigenous Services (ISC)	2024	Premier Health Nordik Inc. (Premier soin Nordik Inc.)	Health Care	$3.5M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Mikisew-International SOS Limited Partnership, International SOS Canada	Health Care	$2.0M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Integra Health Centre	Health Care	$3.5M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Big Hearts Home Healthcare Services Inc.	Health Care	$0.08M	Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Venture Healthcare Inc	Health Care	$12M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Canadian Healthcare Agency LTD.	Health Care	$21M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Bayshore Healthcare Ltd.	Health Care	$12M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Bayshore Healthcare Ltd.	Health Care	$21M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Venture Healthcare Inc.	Health Care	$0.9M	Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Premier Health Nordik Inc. (Premier soin Nordik Inc.)	Health Care	$3.5M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Department of Indigenous Services (ISC)	2024	McCare Global Healthcare Services Inc.	Health Care	$2.0M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Premier Health Nordik Inc. (Premier soin Nordik Inc.)	Health Care	$0.08M	Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Venture Healthcare Inc.	Health Care	$3.5M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Big Hearts Home Healthcare Services Inc.	Health Care	$0.08M	Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Mikisew-International SOS Limited Partnership, International SOS Canada	Health Care	$2.0M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Mikisew-International SOS Limited Partnership, International SOS Canada	Health Care	$0.25M	Alberta	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Canadian Healthcare Agency LTD.	Health Care	$21M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Venture Healthcare Inc.	Health Care	$12M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Canadian Healthcare Agency LTD.	Health Care	$2.0M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Venture Healthcare Inc.	Health Care	$0.25M	Alberta	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Department of Indigenous Services (ISC)	2024	Bayshore Healthcare Ltd.	Health Care	$3.0M	Alberta	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Bayshore Healthcare Ltd.	Health Care	$21M	Ontario	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2024	Bayshore Healthcare Ltd.	Health Care	$12M	Manitoba	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Bayshore Healthcare Ltd.	Health Care	$21M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Venture Healthcare Inc.	Health Care	$0.9M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Canadian Healthcare Agency LTD.	Health Care	$21M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Bayshore Healthcare Ltd.	Health Care	$3.0M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	McCare Global Healthcare Services Inc.	Health Care	$2.0M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Canadian Healthcare Agency LTD.	Health Care	$0.25M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Venture Healthcare Inc.	Health Care	$3.5M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Canadian Healthcare Agency LTD.	Health Care	$2.0M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Department of Indigenous Services (ISC)	2023	Integra Health Centre	Health Care	$3.5M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Bayshore Healthcare Ltd.	Health Care	$12M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Venture Healthcare Inc.	Health Care	$12M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Mikisew-International SOS Limited Partnership, International SOS Canada	Health Care	$0.25M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Premier Health Nordik Inc. (Premier soin Nordik Inc.)	Health Care	$0.08M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Big Hearts Home Healthcare Services Inc.	Health Care	$0.08M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Premier Health Nordik Inc. (Premier soin Nordik Inc.)	Health Care	$3.5M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Mikisew-International SOS Limited Partnership, International SOS Canada	Health Care	$2.0M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Venture Healthcare Inc.	Health Care	$0.25M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Canadian Healthcare Agency LTD.	Health Care	$21M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Department of Indigenous Services (ISC)	2023	Bayshore Healthcare Ltd.	Health Care	$21M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Big Hearts Home Healthcare Services Inc.	Health Care	$0.08M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Venture Healthcare Inc.	Health Care	$3.5M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Integra Health Centre	Health Care	$3.5M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Canadian Healthcare Agency LTD.	Health Care	$2.0M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Venture Healthcare Inc.	Health Care	$0.25M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Venture Healthcare Inc.	Health Care	$12M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Mikisew-International SOS Limited Partnership, International SOS Canada	Health Care	$0.25M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Premier Health Nordik Inc. (Premier soin Nordik Inc.)	Health Care	$3.5M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Venture Healthcare Inc.	Health Care	$0.9M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Department of Indigenous Services (ISC)	2023	Bayshore Healthcare Ltd.	Health Care	$3.0M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Bayshore Healthcare Ltd.	Health Care	$12M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Premier Health Nordik Inc. (Premier soin Nordik Inc.)	Health Care	$0.08M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	McCare Global Healthcare Services Inc.	Health Care	$2.0M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Canadian Healthcare Agency LTD.	Health Care	$0.25M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Department of Indigenous Services (ISC)	2023	Mikisew-International SOS Limited Partnership, International SOS Canada	Health Care	$2.0M	Alberta, Manitoba, Ontario, Quebec	2023-2027	Provide temporary nursing services needed to supplement workforce in delivery primary and public health
Health Canada	2023	Venture Healthcare Inc.	Nursing	$22.0M	Not provided	March, 2023-December 2023	-
Health Canada	2023	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	Feb 2023-June 2023	-
Health Canada	2023	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	Feb 2023-June 2023	-
Health Canada	2023	Canadian Healthcare Agency Ltd.	Nursing	$143.0M	Not provided	Feb 2023-June 2023	-
Royal Canadian Mouted Police	2022	Calian Ltd.	Nursing	$0.2M	Not provided	August 2022-November 2023	-
Royal Canadian Mouted Police	2022	Calian Ltd.	Nursing	$0.3M	Not provided	August 2022-November 2023	-

Appendix F: Overview of federal contracts 2019-2024: obtained from CanadaBuys website (Government of Canada, 2024a)

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Health Canada	2022	Canadian Healthcare Agency LTD.	Nursing	$143M	Not provided	May 2022-June 2023	-
Health Canada	2022	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	Feb 2022-June 2023	-
Health Canada	2022	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	March 2022-June 2023	-
Health Canada	2022	Canadian Healthcare Agency LTD.	Nursing	$1.0M	Not provided	March 2022-June 2023	-
Veterans Affairs Canada	2022	Calian Ltd.	Nursing	$35M	Not provided	March 2022-June 2023	-
Royal Canadian Mouted Police	2022	Calian Ltd.	Nursing	$12M	Not provided	March 2022-June 2022	
Health Canada	2021	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	December 2021-June 2022	-
Health Canada	2021	Canadian Healthcare Agency LTD.	Nursing	$143.0M	Not provided	December 2021-June 2022	-
Health Canada	2021	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	December 2021-June 2022	-
Royal Canadian Mounted Police	2021	Calian Ltd.	Nursing	$1.0M	Not provided	November 2021-November 2022	-
Health Canada	2021	Canadian Healthcare Agency LTD.	Nursing	$37M	Not provided	October 2021-June 2022	-
Health Canada	2021	Canadian Healthcare Agency LTD.	Nursing	$0.5M	Not provided	August 2021-June 2022	-
Health Canada	2021	Canadian Healthcare Agency LTD.	Nursing	$143.0M	Not provided	August 2021-June 2022	-
Health Canada	2021	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	August 2021-June 2022	-
Health Canada	2021	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	August 2021-June 2022	-

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Health Canada	2021	Canadian Healthcare Agency LTD.	Nursing	$143.0M	Not provided	August 2021-June 2022	-
Health Canada	2021	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	August 2021-June 2022	-
Health Canada	2021	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	August 2021-June 2022	-
Royal Canadian Mounted Police	2021	Calian Ltd.	Nursing	$12M	Not provided	May 2021-March 2023	-
Royal Canadian Mounted Police	2021	Calian Ltd.	Nursing	$12M	Not provided	May 2021-March 2023	-
Health Canada	2021	Canadian Healthcare Agency LTD.	Nursing	$143.0M	Not provided	April 2021-June 2022	-
Health Canada	2021	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	April 2021-June 2022	-
Health Canada	2021	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	April 2021-June 2022	-
Veterans Affairs Canada	2021	Calian Ltd.	Nursing	$35M	Not provided	January 2021-March 2023	-
Royal Canadian Mounted Police	2021	Calian Ltd.	Nursing	$12M	Not provided	January 2021-March 2023	-
Veterans Affairs Canada	2020	Calian Ltd.	Nursing	$7.0M	Not provided	November 2020-March 2023	-
Royal Canadian Mounted Police	2020	Calian Ltd.	Nursing	$1.0M	Not provided	November 2020-November 2022	-
Health Canada	2020	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	October 2020-June 2021	-
Health Canada	2020	Canadian Healthcare Agency LTD.	Nursing	$143.0M	Not provided	October 2020-June 2021	-
Health Canada	2020	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	October 2020-June 2021	-

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Public Health Agency of Canada	2020	Bayshore Healthcare Ltd.	Nursing	$1.0M	Not provided	July 2020-June 2020	-
Public Health Agency of Canada	2020	Bayshore Healthcare Ltd.	Nursing	$1.0M	Not provided	June 2020-June 2020	-
Public Health Agency of Canada	2020	Bayshore Healthcare Ltd.	Nursing	$0.5M	Not provided	May 2020-June 2020	-
Public Health Agency of Canada	2020	Bayshore Healthcare Ltd.	Nursing	$0.20M	Not provided	May 2020-June 2020	-
Public Health Agency of Canada	2020	The Canadian Red Cross Society	Nursing	$1.0M	Not provided	May 2020-May 2020	10-day contract
Public Health Agency of Canada	2020	Bayshore Healthcare Ltd.	Nursing	$1.0M	Not provided	May 2020-March 2020	-
Health Canada	2020	Canadian Healthcare Agency LTD.	Nursing	$143.0M	Not provided	April 2020-June 2021	-
Health Canada	2020	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	April 2020-June 2021	-
Health Canada	2020	Bayshore Healthcare Ltd.	Nursing	$60.0M	Not provided	April 2020-June 2021	-
Health Canada	2020	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	April 2020-June 2021	-
Veterans Affairs Canada	2020	Calian Ltd.	Nursing	$35M	Not provided	April 2020-March 2022	-
Health Canada	2020	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	April 2020-June 2021	-
Public Health Agency of Canada	2020	Bayshore Healthcare Ltd.	Nursing	$0.25M	Not provided	March 2020-March 2020	10-day contract
Public Health Agency of Canada	2020	Bayshore Healthcare Ltd.	Nursing	$1.0M	Not provided	February 2020-March 2020	-
Veterans Affairs Canada	2020	Calian Ltd.	Nursing	$5.0M	Not provided	February 2020-March 2022	-

Federal organization	Year awarded/ amended	Agency	Services	Contract value	Region(s) of delivery	Duration of contract	Comments
Public Health Agency of Canada	2020	Bayshore Healthcare Ltd.	Nursing	$0.5M	Not provided	February 2020-March 2020	-
Health Canada	2020	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	February 2020-June 2021	-
Public Health Agency of Canada	2020	Victorian Order of Nurses for Canada	Nursing	$0.5M	Not provided	February 2020-March 2020	-
Health Canada	2019	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	November 2019-June 2021	-
Royal Canadian Mounted Police	2019	Calian Ltd.	Nursing	$12M	Not provided	November 2019-March 2022	-
Health Canada	2019	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	August 2019-June 2021	-
Health Canada	2019	Canadian Healthcare Agency LTD.	Nursing	$143.0M	Not provided	August 2019-June 2021	-
Health Canada	2019	Multi Options Nursing Inc.	Nursing	$5.0M	Not provided	June 2019-June 2021	-
Veterans Affairs Canada	2019	Calian Ltd.	Nursing	$35M	Not provided	June 2019-March 2022	-
Health Canada	2019	Canadian Healthcare Agency LTD.	Nursing services	$143.0M	Not provided	May 2019-June 2021	-
Health Canada	2019	Venture Healthcare Inc.	Nursing	$86.0M	Not provided	May 2019-June 2021	-
Health Canada	2019	Bayshore Healthcare Ltd.	Nursing	$13.5M	Not provided	April 2019-June 2020	-
Veterans Affairs Canada	2019	Calian Ltd.	Nursing	$5.0M	Not provided	March 2019-March 2022	-
Royal Canadian Mounted Police	2019	Calian Ltd.	Nursing	$12M	Not provided	February 2019-March 2022	-
Veterans Affairs Canada	2019	Calian Ltd.	Nursing	$35M	Not provided	February 2019-March 2022	-

Appendix G: Detailed overview of agency hours by jurisdiction during past five fiscal years using available data

Data sources	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 (projected)
British Columbia						
Vancouver Coastal Health (Health Employers Association of British Columbia (HEABC), 2024)	-	-	50,574 RN: 42,616 LPN: 7,958	177,556 RN: 144,888 LPN: 32,668	244,053 (Apr-Dec) RN: 191,432 LPN: 52,621	325,404 255,243 70,161
Fraser Health (Fraser Health Authority, 2024; HEABC, 2024)	-	44,297 (90% RNs)	127,943 (90% RNs)	151,589 (90% RNs)	105,267 (90% RNs) (Apr-Feb)	126,320
Interior Health (HEABC, 2024)	-	-	78,953 RN: 60,359 LPN: 18,594	280,704 RN: 188,909 LPN: 91,795	212,963 (Apr-Dec) RN: 122,155 LPN: 90,808	283,951 162,873 121,077
Northern Health (HEABC, 2024)	-	-	182,984 RN: 99,035 LPN: 83,949	306,144 RN: 148,903 LPN: 157,241	299,506 (Apr-Dec) RN: 146,280 LPN: 153,226	399,341 195,040 204,301
Vancouver Island Health (HEABC, 2024)	-	-	225,359 RN: 198,671 LPN: 26,688	406,593 RN: 323,085 LPN: 83,508	423,762 (Apr-Dec) RN: 295,660 LPN: 128,102	565,016 394,213 170,803
Providence Health Care (HEABC, 2024)	-	-	12,616 (RN only)	23,232 (RN only)	13,259 (RN only)	18,039

Data sources	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 (projected)
Alberta						
Not available						
Saskatchewan						
Saskatchewan Health Authority (SUN, 2023; 2024)	-	-	102,500 (calendar year)	377,899 (calendar year)	493,188 (calendar year)	-
Manitoba						
Shared Health (MNU, 2024)	-	948	131	-	-	
Winnipeg Regional Health Authority (MNU, 2024)	52,052	35,803	62,349	63,835	41,321 (Apr-Feb)	49,585
Prairie Mountain Health (2024; MNU, 2024)	127,482	120,434 RN combined work/travel: 75,211 LPN combined work/travel: 45,223	190,338 RN combined work/travel: 113,113 LPN combined work/travel: 77,225	296,104 RN work: 122,935 RN travel: 42,258 LPN work: 91,717 LPN travel: 39,194	215,770 (Apr-Dec) RN work: 91,797 RN travel: 39,517 LPN work: 57,592 LPN travel: 26,864	287,693 122,396 52,689 76,789 35,819
Southern Health-Santé Sud (2024; MNU, 2024)	27,811	29,243 RN: 18,386 LPN: 10,857	77,477 RN: 43,460 LPN: 34,017	115,385 RN: 68,076 LPN: 47,309	75,731 (Apr-Nov) RN: 45,990 LPN: 29,741	113,597 68,985 44,612
Northern Health Region (2024; MNU, 2024)	65,803	93,011 RN: 81, 236 LPN: 11,775	115,160 RN: 95,522 LPN: 19,638	121,327 RN: 94,990 LPN: 26,337	96,559 (Apr-Dec) RN: 74,787 LPN: 21,772	128,745 99,716 29,029

Data sources	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 (projected)
Interlake-Eastern (2024; MNU, 2024)	55,993	86,564 RN: 60,553 LPN: 26,011	100,364 RN: 72,333 LPN: 28,031	151,516 RN: 99,127 LPN: 52,389	125,011 (Apr-Nov) RN: 84,309 LPN: 40,702	187,517 126,463 61,053
Ontario						
Ontario long-term care homes (AdvantAge Ontario, 2023)	-	-	130% increase from 2020 (all positions)	304% increase from 2020 (all positions)	586% (RN) and 587% (LPN) increase from 2020	-
Ontario hospitals (Grant, 2023a; 2023b; ONA, 2023; Yalnizyan, 2023)	-	449,735	649,002	1.2 M (mostly Q1-Q3) Northern Ontario hospitals – approx. 391,000	-	-
Ontario Hospital 1 survey	-	0	1,440	720	0	-
Ontario Hospital 2 survey	-	0	0	1,187	4,947 (Apr-Dec) RN: 3,927 LPN: 1,020	6,596 5,236 1,360
Ontario Hospital 3 survey	-	0	0	9,245 RN: 7,839 LPN: 1,406	9,987 (Apr-Dec) RN: 8,343 LPN: 1,644	13,316 11,124 2,192
Ontario Hospital 4 survey		9,069 RN: 171 LPN: 8,898	69,948 RN: 14,677 LPN: 55,272	116,742 RN: 29,752 LPN: 86,989	155,395 (Apr-Dec) RN: 31,407 LPN: 123,988	207,193 41,876 165,317

Data sources	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 (projected)
Ontario Hospital 5 survey		-	-	-	6,803 (LPN most frequently needed) (Apr-Dec)	9,071
Quebec						
Health Authority 1 survey		2,546 (all RN)	2,603 RN: 2,569 LPN: 34	13,646 (all RN)	4,745 (all RN) (Apr-Dec)	6,327
Health Authority 2 survey		126,797 RN: 90,853 LPN:35,944	278,537 RN: 175,195 LPN:103,342	328,406 RN: 226,115 LPN:102,765	268,309 (Apr-Dec) RN: 196,779 LPN: 71,531	357,745 262,372 95,375
Health Authority 3 survey		-	91,835 RN: 62,415 LPN: 29,420	110,073 RN: 74,738 LPN: 35,335	191,977 (Apr-Dec) RN: 120,017 LPN: 71,960	255,969 160,023 95,947
Health Authority 4 survey		96,460 RN: 74,677 LPN: 21,783	95,287 RN: 66,251 LPN: 29,036	113,743 RN: 78,755 LPN: 34,988	322,238 (Apr-Dec) RN: 214,204 LPN: 108,034	429,650 285,605 144,045
Health Authority 5 survey		157,743 RN: 102,371 LPN: 55,372	256,531 RN: 165,222 LPN: 91,309	283,201 RN: 184,290 LPN: 98,911	370,812 (Apr-Dec) RN: 221,248 LPN: 149,564	494,416 294,997 199,419
Health Authority 6 survey		471,434 RN: 289,283 LPN: 182,151	540,143 RN: 334,424 LPN: 205,719	504,736 RN: 331,041 LPN: 173,695	572,440 (Apr-Dec) RN: 413,542 LPN: 158,898	659,221 551,389 211,864

Data sources	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 (projected)
New Brunswick						
Vitalité Health Network (Barter, 2024b; CBC News, 2023)				20,098 July-Dec (3 agencies only)	237,183 Sept-Mar	406,599
Horizon Health Network survey				31,287	236,043 (Apr-Dec)	314,724
Nova Scotia	Not available					
Prince Edward Island	Not available					
Newfoundland and Labrador	Not available					
Northwest Territories	Not available					
Yukon	Not available					
Federal organization						
Survey from federal organization (provides health care services in Alberta, Manitoba, Ontario, Quebec)		420,347 RN: 404,144 LPN: 10,876 NP: 5,327	495,450 RN: 463,961 LPN: 20,179 NP: 11,310	333,167 RN: 330,324 LPN: 2,843	132,930 (all RNs) (Apr-Jan)	159,516

Appendix H: Overview of available data sources used in Figure 5: total agency hours used by health care facilities

Bolded numbers are values used in Figure 5. Some data sources reported only "total agency hours" without breakdown between RNs and LPNs. Others provided "total agency hours" and "total agency hours for RNs, LPNs and NPs" (where applicable). Therefore, when "total agency hours for RNs and LPNs" numbers are added together, they will not always equal "total agency hours."

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 projected
British Columbia					
Sum of data listed below for provincial health authorities					
Total agency hours Total RN agency hours Total LPN hours	44,297 - -	678,429 413,297 137,189	1,345,818 829,017 365,212	Data below used for next column: 2023-2024 (estimated)	1,718,071 1,025,408 566,342
Vancouver Coastal Health (Health Employers Association of British Columbia (HEABC), 2024)	-	Total: 50,574 RN: 42,616 LPN: 7,958	Total: 177,556 RN: 144,888 LPN: 32,668	Total: 244,053 (Apr-Dec) RN: 191,432 LPN: 52,621	Total: 325,404 RN: 255,243 LPN: 70,161
Fraser Health (Fraser Health Authority, 2024; HEABC, 2024)	44,297	Total: 127,943	Total: 151,589	Total: 105,267 (Apr-Feb)	Total: 126,320
Interior Health (HEABC, 2024)	-	Total: 78,953 RN: 60,359 LPN: 18,594	Total: 280,704 RN: 188,909 LPN: 91,795	Total: 212,963 (Apr-Dec) RN: 122,155 LPN: 90,808	Total: 283,951 RN: 162,873 LPN: 121,077

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 projected
Northern Health (HEABC, 2024)	-	Total: 182,984 RN: 99,035 LPN: 83,949	Total: 306,144 RN: 148,903 LPN: 157,241	Total: 299,506 (Apr-Dec) RN: 146,280 LPN: 153,226	Total: 399,341 RN: 195,040 LPN: 204,301
Vancouver Island Health (HEABC, 2024)	-	Total: 225,359 RN: 198,671 LPN: 26,688	Total: 406,593 RN: 323,085 LPN: 83,508	Total: 423,762 (Apr-Dec) RN: 295,660 LPN: 128,102	Total: 565,016 RN: 394,213 LPN: 170,803
Providence Health Care (HEABC, 2024)	-	12,616 (total and RN only)	23,232 (total and RN only)	13,259 (total and RN only)	18,039 (total and RN only)
Saskatchewan					
Total agency hours	-	102,500	377,899	Data below used for next column: 2023-2024 (estimated)	493,188
Saskatchewan Health Authority (SUN, 2023; 2024)	-	Total: 102,500 (calendar year)	Total: 377,899 (calendar year)	Total: 493,188 (calendar year)	Total: 493,188
Manitoba					
Sum of data listed below for provincial health authorities					
Total agency hours Total RN agency hours Total LPN hours	366,003 154,150 93,866	545,819 324,428 158,911	748,167 427,386 256,946	Data below used for next column: 2023-2024 (estimated)	767,137 470,249 247,302
Shared Health (MNU, 2024)	Total: 948	Total: 131	-	-	
Winnipeg Regional Health Authority (MNU, 2024)	Total: 35,803	Total: 62,349	Total: 63,835	Total: 41,321 (Apr-Feb)	Total: 49,585

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 projected
Prairie Mountain Health (2024; MNU, 2024)	120,434 RN: 75,211 LPN: 45,223	190,338 RN: 113,113 LPN: 77,225	296,104 RN: 165,193 LPN: 130,911	Total: 215,770 (Apr-Dec) RN: 131,314 LPN: 84,456	Total: 287,693 RN: 175,085 LPN: 112,608
Southern Health-Santé Sud (2024; MNU, 2024)	Total: 29,243 RN: 18,386 LPN: 10,857	Total: 77,477 RN: 43,460 LPN: 34,017	Total: 115,385 RN: 68,076 LPN: 47,309	Total: 75,731 (Apr-Nov) RN: 45,990 LPN: 29,741	Total: 113,597 RN: 68,985 LPN: 44,612
Northern Health Region (2024; MNU, 2024)	Total: 93,011 RN: 81, 236 LPN: 11,775	Total: 115,160 RN: 95,522 LPN: 19,638	Total: 121,327 RN: 94,990 LPN: 26,337	Total: 96,559 (Apr-Dec) RN: 74,787 LPN: 21,772	Total: 128,745 RN: 99,716 LPN: 29029
Interlake-Eastern (2024; MNU, 2024)	Total: 86,564 RN: 60,553 LPN: 26,011	Total: 100,364 RN: 72,333 LPN: 28,031	Total: 151,516 RN: 99,127 LPN: 52,389	Total: 125,011 (Apr-Nov) RN: 84,309 LPN: 40,702	Total: 187,517 RN: 126,463 LPN: 61,053
Ontario					
Sum of data listed below for hospitals					
Total agency hours	449,735	649,002	1,200,000	-	1,200,000* (see note)
Ontario hospitals (Grant, 2023a; 2023b; ONA, 2023; Yalnizyan, 2023)	449,735	649,002	1.2 M	-	-
Quebec					
Sum of data listed below for provincial health authorities					
Total agency hours Total RN agency hours Total LPN hours	854,980 559,730 295,250	1,264,936 806,076 458,860	1,353,805 908,585 445,694	Data below used for next column: 2023-2024 (estimated)	2,203,328 1,560,713 746,650

Data source	2020-2021	2021-2022	2022-2023	2023-2024 (mostly Q1-Q3)	2023-2024 projected
Health Authority 1 survey	2,546 (total and RN only)	Total: 2,603 RN: 2,569 LPN: 34	13,646 (total and RN only)	4,745 (total and RN only) (Apr-Dec)	6,327 (total and RN only)
Health Authority 2 survey	Total: 126,797 RN: 90,853 LPN:35,944	Total: 278,537 RN: 175,195 LPN:103,342	Total: 328,406 RN: 226,115 LPN:102,765	Total: 268,309 (Apr-Dec) RN: 196,779 LPN: 71,531	Total: 357,745 RN: 262,372 LPN: 95,375
Health Authority 3 survey		Total: 91,835 RN: 62,415 LPN: 29,420	Total: 110,073 RN: 74,738 LPN: 35,335	Total: 191,977 (Apr-Dec) RN: 120,017 LPN: 71,960	Total: 255,969 RN: 160,023 LPN: 95,947
Health Authority 4 survey	Total: 96,460 RN: 74,677 LPN: 21,783	Total: 95,287 RN: 66,251 LPN: 29,036	Total: 113,743 RN: 78,755 LPN: 34,988	Total: 322,238 (Apr-Dec) RN: 214,204 LPN: 108,034	Total: 429,650 RN: 285,605 LPN: 144,045
Health Authority 5 survey	Total: 157,743 RN: 102,371 LPN: 55,372	Total: 256,531 RN: 165,222 LPN: 91,309	Total: 283,201 RN: 184,290 LPN: 98,911	Total: 370,812 (Apr-Dec) RN: 221,248 LPN: 149,564	Total: 494,416 RN: 294,997 LPN: 199,419
Health Authority 6 survey	Total: 471,434 RN: 289,283 LPN: 182,151	Total: 540,143 RN: 334,424 LPN: 205,719	Total: 504,736 RN: 331,041 LPN: 173,695	Total: 572,440 (Apr-Dec) RN: 413,542 LPN: 158,898	Total: 659,221 RN: 551,389 LPN: 211,864
New Brunswick					
Sum of data listed below for provincial health authorities					
Total agency hours Total RN agency hours Total LPN hours	- - -	- - -	51,385	Data below used for next column: 2023-2024 (estimated)	721,323

Data source	2020–2021	2021–2022	2022–2023	2023–2024 (mostly Q1–Q3)	2023–2024 projected
Vitalité Health Network (Barter, 2024b; CBC News, 2023)	–	–	Total: 20,098 (July-Dec)	Total: 237,183 (Sept-Mar)	Total: 406,599
Horizon Health Network survey	–	–	Total: 31,287	Total: 236,043 (Apr–Dec)	Total: 314,724
Federal organization					
Sum of data listed below					
Total agency hours (includes NPs) Total RN agency hours Total LPN hours	420,347 404,144 10,876	495,450 463,961 20,179	333,167 330,324 2,843	Data below used for next column: 2023–2024 (estimated)	159,516 159,516 –
Survey from federal organization (provides health care services in Alberta, Manitoba, Ontario, Quebec)	Total: 420,347 RN: 404,144 LPN: 10,876 NP: 5,327	Total: 495,450 RN: 463,961 LPN: 20,179 NP: 11,310	Total: 333,167 RN: 330,324 LPN: 2,843	132,930 (total and RNs only) (Apr–Jan)	159,516 (total and RNs only)

*Note: Comparable data not available for Ontario in 2023–2024, therefore data from 2022–2023 was used.

Appendix I: Overview of available data sources used in Figure 7: comparison of total agency costs and total agency hours

See Figure 7.

Data source	2020–2021		2021–2022		2022–2023		2023–2024 projected	
	Total agency hours	Total agency cost	Total agency hours	Total agency cost	Total agency hours	Total agency cost	Total agency hours	Total agency cost
British Columbia								
Vancouver Coastal Health (HEABC, 2024; Vancouver Coastal Health, 2024b)	-	-	50,574	$6.1M	177,556	$24.1M	325,404	$27.4M
Fraser Health (Daflos, 2022; Fraser Health Authority, 2024; HEABC, 2024)	44,297	$4.7M	127,943	$11.8M	151,589	$14.7M	126,320	$13.4M
Saskatchewan								
Saskatchewan Health Authority (SUN, 2023; 2024)	-	-	102,500	$12.3M	377,899	$45.3M	493,188	$59.2M
Manitoba								
Shared Health (MNU, 2024)	948	$63,330	131	$8,923	-	-	-	-
Winnipeg Regional Health Authority (MNU, 2024)	35,803	$2.6M	62,349	$4.1M	63,835	$4.1M	-	-
Prairie Mountain Health (2024; MNU, 2024)	120,434	$14M	190,338	$28M	296,104	$23.1M	287,693	$22.5M

Data source	2020–2021		2021–2022		2022–2023		2023–2024 projected	
	Total agency hours	Total agency cost	Total agency hours	Total agency cost	Total agency hours	Total agency cost	Total agency hours	Total agency cost
Southern Health-Santé Sud (2024; MNU, 2024)	29,243	$2.1M	77,477	$5.6M	115,385	$8.1M	113,597	$8.7M
Northern Health Region (2024; MNU, 2024)	93,011	$8M	115,160	$10.4M	121,327	$12.9M	128,745	$14.4M
Interlake-Eastern (2024; MNU, 2024)	86,564	$6.7M	100,364	$7.7M	151,516	$11.5M	187,517	$14.7M
Ontario								
Ontario hospitals (ONA, 2023)	449,735	$38.1M	649,002	$68.4M	1,200,000	$154M	-	-
Quebec								
Health Authority 1 survey	2,546	$0.2M	2,603	$0.3M	13,646	$1.2M	6,327	$1.1M
Health Authority 2 survey	126,797	$15.8M	278,537	$36M	328,406	$54.8M	357,745	$57.6M
Health Authority 3 survey	-	-	91,835	$3.1M	-	-	255,969	$35.1M
Health Authority 4 survey	96,460	$6.8M	95,287	$6.3M	113,743	$9M	429,650	$29.6M
Quebec Health Authority 5 survey	157,743	$13M	256,531	$24.7M	283,201	$27.8M	494,416	$62.7M
Quebec Health Authority 6 survey	471,434	$41.7M	540,143	$36.6 M	504,736	$39M	659,221	$90.7M
New Brunswick Vitalité Health Network (Barter, 2024b; CBC News, 2023)	-	-	-	-	20,098	$5.9M	406,599	$117.4M
New Brunswick Horizon Health Network survey	-	-	-	-	31,287	$5M	314,724	$54.80
Federal organization survey	420,347	$58.9M	495,450	$73.8M	333,167	$51.5M	159,516	$26M

Appendix J: Hourly rates paid to agencies by health care facilities by jurisdiction and who paid for direct or indirect costs during past three fiscal years using available data

Note: In a small number of data sources, it was not clear if the reported data referred to "hourly agency rates paid to agencies by health care facilities" or "hourly wages paid to nurses by agencies." These data sources are included in the description of the "hourly agency rates" when other data sources were not available for a health care facility, province or territory.

	2021-2022	2022-2023	2023-2024	Direct costs paid by health authority/ hospital	Indirect costs paid by health authority/ hospital	Costs paid by agency or individual nurse
British Columbia						
Across province (Daflos, 2022; 2023b; Ruttle, 2023)	RN average: ~ $70.45	RN: one agency was charging $115	LTC: $80-110	Travel expenses if greater than 50 kilometres		
Vancouver Coastal Health (2024c)	General RN: $69.12 RPN: $71.60 LPN: $59.00 NP: $79.10 One agency charged $93-110 for specialty RNs	General RN: $70.47 RPN: $73.00 LPN: $60.15 NP: $80.64 One agency charged $93-110 for specialty RNs	General RN: $71.84 RPN: $74.42 LPN: $61.32 NP: $82.21 One agency charged $93-110 for specialty RNs	Agency vendors can invoice for reasonably incurred expenses and only for actual out-of-pocket costs or expenses. Instructed to avoid service fees, administrative fees or other additional costs.		
Fraser Health Authority (2024)	General RN: $69.12 Specialty RN: $71.60 RN certified practice: $74.17 RPN: $71.60 LPN: $59.00 NP: $79.10	General RN: $70.47 Specialty RN: $73.00 RN certified practice: $75.62 RPN: $73.00 LPN: $60.15 NP: $80.64	General RN: $71.84 Specialty RN: $74.42 RN certified practice: $77.09 RPN: $74.42 LPN: $61.32 NP: $82.21	No additional fees. Hourly rate regulated by Provincial Health Services Authority (PHSA) and mandated by Ministry of Health.		

<table>
<tr><th></th><th>2021-2022</th><th>2022-2023</th><th>2023-2024</th><th>Direct costs paid by health authority/ hospital</th><th>Indirect costs paid by health authority/ hospital</th><th>Costs paid by agency or individual nurse</th></tr>
<tr><td colspan="7">Alberta</td></tr>
<tr><td>Rural and remote locations (French, 2023)</td><td></td><td>$85
(based on advertisement)</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Saskatchewan</td></tr>
<tr><td>Saskatchewan Health Authority (SUN, 2023; 2024)</td><td>$120</td><td>$120</td><td>$120</td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Manitoba</td></tr>
<tr><td>Prairie Mountain Health (2024)</td><td colspan="3">RN: $65
LPN: $50
NP: $85

Rates set by province via the Provincial Multi Service Agency Agreement and Fee Schedule and not able to negotiate on these rates with the agencies.</td><td>Travel fee.
General holidays and overtime paid at 1.5 times regular rate.
Additional $1.00/hour if nurse in charge.</td><td></td><td></td></tr>
<tr><td>Southern Health-Santé Sud (2024)</td><td></td><td colspan="2">RN average: $78.40
Range: $65.00-162.50

LPN average: $66.15
Range: $50.00-125.00

NP average: $127.36
Range: $85.00-212.50

Average rate includes direct and indirect cost divided by hours paid.
Minimum rate is exclusive of any direct or indirect costs.
Maximum rate paid if hours are worked on a general holiday.</td><td>Practice area.
Overtime hours. General holidays.
Nurse in charge.

Travel time if greater than one hour each way, to and from the site, as well as kilometres reimbursement for personal vehicle use.

May pay accommodation, typically to the accommodation provider, not agency.</td><td></td><td></td></tr>
<tr><td>Northern Health Region (2024)</td><td colspan="3">RN range $65-130
LPN range $50-100
RPN range $65-130</td><td>Travel and per diem</td><td></td><td></td></tr>
</table>

	2021-2022	2022-2023	2023-2024	Direct costs paid by health authority/ hospital	Indirect costs paid by health authority/ hospital	Costs paid by agency or individual nurse
Interlake-Eastern Regional Health Authority (2024)	RN: $65 LPN: $50 NP: $85 Rates set by province via the Provincial Multi Service Agency Agreement and Fee Schedule and not able to negotiate on these rates with the agencies.			Travel		
Ontario						
Province (Grant, 2023a)	Average: $134.91	A handful of hospitals reported $250 for RN		Accommodations. Travel.		
Ontario hospitals (ONA, 2023)	RN average: $134.91 2020-2021 RN average: $74.38	General RN average: $112.56 General RN range: $53.50-260 Specialty RN average: $128.79 Specialty RN range: $81.20-195				
Ontario long-term care homes (AdvantAge Ontario, 2023; Office of the Auditor General of Ontario, 2023b)		RN average: $97.33/hr RN range $55 to 139.65/hr Some homes were charged: RN: $210 LPN: $165		Agency service fees up to 35%. Premiums for short-notice staff (e.g., $100 per shift). Travel costs (mileage, etc). One remote location: accommodation, transportation subsidies (one home paid $115/night for accommodation)		
Ontario Hospital 1 survey			$80	Travel. Parking. Rural settings: pay for food and accommodations.	ID badge. Computer access. Orientation. Training equipment. Scheduling. For no-shows.	

	2021-2022	**2022-2023**	**2023-2024**	**Direct costs paid by health authority/ hospital**	**Indirect costs paid by health authority/ hospital**	**Costs paid by agency or individual nurse**
Ontario Hospital 2 survey			Average RN: $127.30 Range: $96.27-156.90 Average LPN: $95.78 Range: $67.45-129.90	Specialty RN (ED/ICU). One agency: 35% service fee. Two agencies: daily per diem ranging from $40 to $60/day. Meal allowance sometimes required. Housing and travel vary by agency – most agencies bill hospital. Taxi to and from hospital if nurse does not own vehicle and not within walking distance.	ID badge. Training/ orientation.	One agency: paid up to $1500/month for accommodation (hospital was still responsible for sourcing). One agency: paid for transportation into community.
Ontario Hospital 3 survey			RN average: $104.50 LPN average: $88	Overtime.	Orientation. Employee health. Human resources. Payroll/scheduling. Accounts payable.	Nurse: own accommodation, travel and parking.
Ontario Hospital 4 survey			RN average: $108.23 Range $79.40-120 LPN average: $89.42 Range: $62.50-109	1 agency: 25% on top of hourly rate. 1 agency: $50/day for food allowance. Accommodation. Travel. Parking.	ID badges. Orientation. Computer training. Scheduling support.	
Ontario Hospital 5 survey				Accommodation Travel Per diem.	ID badge. Orientation. Scheduling support. Computer training.	Nurse: parking.
Ontario Hospital 6 survey			RN average: $90			Agency: travel and accommodation. Nurse: parking.

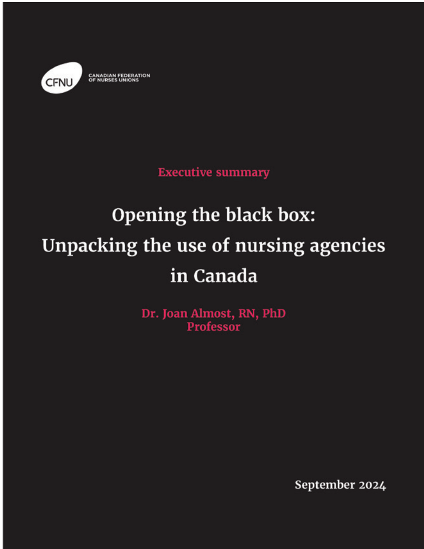
	2021-2022	2022-2023	2023-2024	Direct costs paid by health authority/ hospital	Indirect costs paid by health authority/ hospital	Costs paid by agency or individual nurse
Quebec						
Health Authority 1 survey			RN average: $117.94 Range: $70.94-140			
Health Authority 2 survey			RN average: $127.44 Range: $84.75-165 LPN average: $91.77 Range: $64- 125	120$/day for accommodation; kilometers/travel.	Medical material.	Agency: badges, training, uniforms. Agency and/or nurse: parking.
Health Authority 3 survey			RN average: $122.7 Range: $78.99-155 LPN average: $90.26 Range: $60.44-120	Rural settings – pay for travel and accommodations (may also be paid by agency).		Agency: Orientation Vaccination Mask fit test. Nurse: parking.
Health Authority 4 survey			RN average: $88.48 LPN average: $57.44	Practice setting – based on level of education (e.g., obstretrics.	Orientation and integration. On-site professional development. Scheduling.	Nurse: own accommodation, travel and parking.
Health Authority 5 survey			RN average: $144.68 Range: $69.75-175 LPN average: $100.35 Range: $69-105	Overtime allowed in certain sites. Travel. Accommodation.		Agency: Orientation. Professional development. Nurse: parking
Health Authority 6 survey			RN average: $129.95 Range: $83-160 LPN average: $90.03 Range: $47.65-105	Parking. Accommodations and travel may be paid by HA and/or agency.		Agency: Orientation Professional development

	2021-2022	2022-2023	2023-2024	Direct costs paid by health authority/ hospital	Indirect costs paid by health authority/ hospital	Costs paid by agency or individual nurse
New Brunswick						
Vitalité Health Network (CBC News, 2023; Ha, 2024b; Ha et al., 2024)		July to December average cost: $295 July 2022 to September 2023 – one agency charged $300.72 for mix of RNs and LPNs Contract for December 2022 to February 2026 – $306.70 2 other agencies: $112-141		$46/day in meal allowances. Accommodations, hotels (one agency charged $219/night). Travel. Administrative costs.		
Vitalité Health Network (Auditor General of New Brunswick, 2024)	3 agencies: RN range – $120-169.6/hr 2 agencies: LPN range – $90-124.8/hr One agency: only offered bundled pricing model. A team up to 12 hrs/day = $18,043.42 per team/day (one contract) or $18,403.42 per team/day (second contract). A team was comprised of virtual staff (1 operations lead, 1 clinical lead, 0.44 scheduler) and in person (0.22 logistics lead, 2 LPNs, 3 RNs). This was calculated as $306/hr for LPN or RN, which includes all non-direct care staffing costs.			Car rentals Airfare Accommodations House rental Meal allowances		
Horizon Health Network Survey		Average: $131 Range: $95-170	RN: $125 LPN: $95	Specialty practice (operating room or emergency department). Short-notice shift. Travel.	Online orientation. Computer training.	Agency: accommodation, parking
Horizon Health Network (Auditor General of New Brunswick, 2024)		RN range: $85-160/hr LPN range: $70-110/hr		Car rental accommodations		

	2021-2022	2022-2023	2023-2024	Direct costs paid by health authority/ hospital	Indirect costs paid by health authority/ hospital	Costs paid by agency or individual nurse
Department of Social Development (Auditor General of New Brunswick, 2024)		One agency: RN ($89.50); LPNs ($59.50) One agency: only offered bundled pricing model at $9,995/team/day, which included: 1) a team day up to 8 hrs/day; and 2) a team comprised of virtual staff (½ team lead, ½ clinical lead, 1 scheduler) and in-person staff (1 logistics manager, 5 certified PSW's, 1 RN, 1 LPN)		Car rentals Accommodations Flights Hotel rooms Gift cards		
Nova Scotia						
Seniors and long-term care (Luck, 2022; Nova Scotia Seniors and Long-Term Care, 2022)	RN range: $134.80 to $138.60 LPN: $124.80			$3,000/month for accommodations. Up to $1,000 in travel expenses such as vehicle rental. Cellphone. $20,000-$120,000 one-time funding to agency for clerical support (e.g., invoicing, accommodation booking).		
Prince Edward Island						
Health PEI (2024; Ross, 2023)	$100/hr		RN1 average: $113.93 Range: $77.80-170 RN2 average: $117.35 Range: $77.80-150 LPN average: $86.17 Range: $42.87-120	Meal per diem. Accommodations. Travel to province. Travel to and from accommodation to facility.		

	2021-2022	2022-2023	2023-2024	Direct costs paid by health authority/ hospital	Indirect costs paid by health authority/ hospital	Costs paid by agency or individual nurse
Newfoundland and Labrador						
Regional health authorities (Ha, 2024b; Ha et al., 2024)			Western region (1 agency) General RN: $283.63 Specialty RN: $312.35 Central region (2 agencies) RN: $145-172.22 Eastern region (1 agency) RN: $120-159.50 N.L. Eastern, Central, Western, Labrador Regions (1 agency): $120 NP – $235	Travel. Accommodations. Infield onboarding services. Professional development, such as courses and textbooks. Travel to and from province (mileage or airfare). Cab fair to and from airport. Furniture, bills, appliances. Meal per diem.		
Northwest Territories						
Northwest Territories Health and Social Services Authority (Carroll, 2024; Northwest Territories Legislative Assembly, 2024)			Average: $125 Range: $105-164 Entry level: $98-101 Specialty: $102-105	Per diem. Accommodation. Up to $146.25 for travel. Up to $950 for provincial registration fees. Travel time up to 7.5 hours each way at $35/hr. Month of March: $500 peak time bonus if work in NWT for over 2 weeks. Union dues (NTHSSA only) Shift premium Call back		

	2021-2022	2022-2023	2023-2024	Direct costs paid by health authority/ hospital	Indirect costs paid by health authority/ hospital	Costs paid by agency or individual nurse
Yukon						
Yukon Health and Social Services Survey			RN average: $113 RN range: $97-129	Expanded nursing scope. Travel. Accommodations (agency also covers). Parking. Per diem. Provincial registration fees.	Orientation. Scheduling. Specific software training. X-ray training.	
Federal organization						
Survey from federal organization, (provides health care services in Alberta, Manitoba, Ontario, Quebec)	Cannot disclose any information pertaining to rates in order to safeguard third-party information			Accommodations (agency also covers). Travel covered by government and agency. Contractors may be entitled to an incentive fee.		Agency and/or nurse: Parking. Protective clothing/ equipment. Certifications. Agency: orientation/ continuous learning, travel agency fees.



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Full report

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