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Running on Empty: Ontario Hospital Workers' Mental Health and Well-Being Deteriorating Under Austerity-Driven System

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Abstract

The well-being of health care workers (HCWs) and the public in Ontario, Canada is at risk as the province's health care system is strained by neoliberal restructuring and an aging population. Deteriorating working conditions that preceded the COVID-19 pandemic further declined as the added challenges took their toll on the work force, physically and mentally. The predominantly female, racialized, and pandemic-weary hospital staff are facing unprecedented challenges. They are experiencing stress, anxiety, and burnout from staffing shortages and the resulting increased workloads, long hours, and violence. Comprehensive telephone interviews were conducted with 26 HCWs from less highly paid occupations in a range of hospitals across the province. Thematic analysis reveals a critical need for policies and legislation ensuring increased funding, hospital capacity, and reduced wait times while providing HCWs with fair and equitable wages, increased staffing, mental health supports, greater respect and acknowledgment, and strong protections from violence and other workplace hazards.

Keywords

health care workers, mental health, neoliberalism, conditions of work

Extrait

Le bien-être des travailleuses et travailleurs de la santé et de la population de l'Ontario (Canada) est à menacé puisque le système de santé de la province est fragilisé par une restructuration néolibérale et une population vieillissante. La dégradation des conditions de travail qui a précédé la pandémie de la COVID-19 s'est aggravée davantage puisque les défis supplémentaires ont eu des conséquences sur la main-d'œuvre, physiquement et mentalement. Le personnel hospitalier majoritairement féminin et racisé, épuisé par la pandémie, est confronté à des défis sans précédents. Ces membres du personnel souffrent de stress, d'anxiété et d'épuisement professionnel en raison du manque de personnel et des charges de travail accrues qui en résultent, des longues heures de travail et de la violence. Des entrevues téléphoniques exhaustives ont été menées auprès de vingt-six travailleuses et travailleurs de la santé dans des professions les moins bien payées dans divers hôpitaux des quatre coins de la province. L'analyse thématique révèle un besoin pressant pour des politiques et des lois qui assureraient un financement accru, la capacité d'hospitalisation et des temps d'attente réduits tout en offrant aux travailleuses et travailleurs de la santé des salaires justes et équitables, une augmentation des effectifs, des soutiens en santé mentale, un plus grand respect et une meilleure reconnaissance, ainsi que des protections musclées contre la violence et d'autres risques au travail.

Introduction

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

The health care system in Canada is under strain due to austerity-driven cost-cutting measures along with additional

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demands due to the COVID-19 pandemic.[1] In Canada additional strains have resulted from increasingly complex medical challenges, many related to the aging population and related multimorbidity, and population growth.[2,3] This study addresses hospital work in the Canadian province of Ontario where, as health care delivery and access conditions deteriorated over several decades, health care workers (HCWs) and the public have increasingly confronted the risk of harm.[4] Unlike other jurisdictions, the highly unionized HCWs in Ontario do not have the right to strike as a strategy for improving conditions.[5] Since the onset of the pandemic in 2020, hospital staff and professionals have faced unprecedented workload challenges. One of the foundations of overwork is understaffing,[6,7] which leads to heavier workloads, poorer care, and increased strain and health and safety risks. In turn, they are experiencing negative physical and mental effects, including stress and anxiety.[8–12] Burnout and negative coping strategies have also increased[13] and patient care is compromised.[14]

These burdens of stress and overwork preceded and were exacerbated by the COVID-19 pandemic.[14–16] According to Canadian researchers who are making an argument for structural change to the system: "COVID-19 has exposed the grim underbelly of a fragmented, regionalized, costly, and inefficient approach to health service that is an engine for health work force burnout."[17] In a 2023 survey, 78% of Ontario-based registered practical nurses (RPNs) reported reaching a breaking point related to their job in that year: "In the height of the COVID-19 pandemic, 71 percent of nurses reported feeling this way, and yet, two years later, this figure continues to rise."[18] A study of Canadian HCWs' mental health during the pandemic found social class differences whereby the less highly paid segment of HCWs suffered the most impact.[19]

Moral distress and moral injury, terms first used to describe traumatic effects on military personnel, became more widely used for HCWs over the course of the pandemic.[20] Moral distress can result "when you know the ethically correct action to take but you are constrained from taking it."[21] Moral injury refers to "the damage done to one's conscience or moral compass when that person perpetrates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical codes of conduct."[22] The terms refer to the harm done to HCWs who suffer morally as well as psychologically and physically.[23]

HCWs are increasingly challenged by ethical considerations. According to Danish researchers:

> Nursing is rooted in a holistic approach with an ethical obligation to maintain and respect the individual's dignity and integrity. …Working within time limits and heavy work load leads to burnout and ethical insensitivity among nurses, and may challenge nurses' options to act on the basis of ethical and moral grounds in the individual care situation.[24]

The qualitative study reported here was conducted in collaboration with the Ontario Council of Hospital Unions/ Canadian Union of Public Employees (OCHU/CUPE). OCHU is the central bargaining council for many HCWs represented by CUPE, Canada's largest public-sector union. OCHU has a membership of approximately 40 000 hospital, long-term care (LTC), ambulance, and other allied workers within health care services and facilities across the province. OCHU has become increasingly concerned about the physical and mental well-being of HCWs experiencing stress and exhaustion from 4 years of pandemic health care in what was already an understaffed, under-resourced system. This study follows prior collaborative research on verbal, physical, and sexual violence against HCWs in 2017 and 2019[25,26] and HCWs' experiences in 2020 during the early months of the pandemic. The latter found HCWs suffering from increased exhaustion, burnout, fear, anxiety, and frustration.[8,12,27]

The purpose of this research was to gain insights into the perceptions, concerns, and experiences of the less highly paid hospital staff in Ontario's under-resourced and inherently hierarchical health care system. This is a seldom researched HCW cohort, as most studies focus on physicians, surgeons, and registered nurses (RNs). It undertook to understand better the structural and psychosocial factors that lie behind HCWs' stress, burnout, and poor mental health and to give voice to the HCW community, identifying problems from their own perspectives and lived experience. It sought to gather their ideas and recommendations for improvements. OCHU, in conjunction with other health care unions and community advocacy allies, will use the results to shape further research, health care policy, and regulatory decisions.

Background

Devolution of Ontario, Canada Health Care System

Canada has generally been viewed as having a high-quality public system.[28] It has had a universally accessible, publicly funded system since 1966 when the Medical Care Act was passed.[29] Since 1984, when the Canada Health Act was enacted, extra-billing has been prohibited, thus ensuring that all medically essential hospital and doctors' services are provided free of charge. The federal government provides funding to each province and territory, which is responsible for its own plans.[30,a]

To be eligible for full federal funding, they must follow five requirements. Health care must be publicly administered, comprehensive in coverage conditions, universal, portable across provinces, and accessible (e.g., requiring no user fees). However, the once esteemed system is now in steep decline: in 1976 Canada had about 7 hospital beds per 1000 people[31]; in 2024, the number had dropped to 2.6.[32] In 2004, Canada held 4th place out of 11 high-income countries in terms of health care performance[33] but fell to 10th place in 2021; Canada ranked slightly above the United

States when compared to the other Organization for Economic Cooperation and Development (OECD) countries, but both are at the bottom of the list.[34]

Using public funds to pay for health care in private/for-profit facilities is the Ontario government's rationale "to increase capacity and reduce wait times. However, expanding the for-profit sector is unlikely to do either: capacity depends on the availability of qualified staff, which is unchanged by the addition of profit."[35] Privatization escalated as the pandemic revealed the public system's inadequacies.[36] For example, public hospitals depend more on private nursing agencies to provide contract nurses as needed rather than hire a sufficient complement of permanent staff.[37]

The depletion of hospital staffing in Ontario is worse than in most of the other provinces. Health care researcher Doug Allan found that hospitals in other Canadian provinces average "… 18 percent more staff per capita than hospitals in Ontario."[38] There is a severe shortage of nurses and personal support workers (PSWs) in hospitals and LTC facilities. The shortages are projected to increase substantially over the next 5 years.[39] The provincial system is unstable as hospitals and LTC facilities reach and exceed capacity. There are frequent emergency department/emergency room (ER) closings and long wait times for care.[37]

A decreasing real wage contributes to staff retention difficulties and HCWs' sense of being exploited.[40] Wage increases have not kept up with inflation and are lower than in most other industries; the average wage for health and social assistance jobs compared to the average all-industry wage dropped from 102.4% in 2017 to 93.9% in 2023.[41] The Ontario Health Coalition reported: "Ontario ranks at or near the bottom of the country in key health care funding measures" and, in terms of hospital spending, is "dead last." It further states: "… government has repeatedly underspent its planned health care budget for years, choosing to impose real dollar wage cuts as staffing shortages worsened and refusing to increase service levels even as health care services have fallen into unprecedented crisis."[42] The Financial Accountability Office of Ontario (FAO) "projects a net funding shortfall over the six-year period from 2022-23 to 2027-28 of $21.3 billion."[39]

Using documents garnered through Freedom of Information requests, the Canadian Centre for Policy Alternatives (CCPA) found that the government intends to privatize Ontario's health care system further. In 2023, it reported there were: "… plans to significantly expand publicly funded surgeries and diagnostic procedures performed in for-profit facilities."[35] CCPA cautions: "For-profit surgical and diagnostic delivery comes at the expense of public hospitals and undermines efforts to reduce surgical wait times over the long term."

Increasingly challenging working conditions, along with growing privatization and problems with retention of hospital staff, have led to a sustained outcry from the public for improvements[43,44] and from workers for increased staffing, mental health services, a reduced workload, recognition of the multifactorial impacts on their health and well-being, and more equitable wages.[45]

Impacts on Health Care Workers

Poor HCW mental health is a global phenomenon.[46] It is arguably related, at least partly, to the decline in the health care system and its working conditions. Grady et al. conducted research on HCWs in collaboration with the Mental Health Commission of Canada, and they identified that 37% of respondents were experiencing burnout. They noted increasing demands and diminishing support and that "The COVID-19 pandemic has worsened these poor working conditions, negatively impacting mental health and exacerbating feelings of moral distress."[47]

The Registered Nurses Association of Ontario reports: "nurses are experiencing depression, anxiety and stress as never before." This has led to significant problems with staff retention. The report states they are: "migrating to nursing agencies for fairer compensation and more control over their lives"; attrition is especially pronounced among younger, early career nurses, who are more likely to leave their positions.[48] The FAO of Ontario reports the vacancy rate within the health sector "has nearly doubled since 2019" and warns that "High vacancy rates can result in staff shortages and impact public services."[49]

In 2022 OCHU/CUPE collaborated with two other Ontario unions representing a segment of HCWs, Service Employees International Union (SEIU) and Unifor. A survey of their members was conducted in Ontario and found poor working conditions affect hospital staff retention. Almost a third of RPNs are considering leaving nursing, contributing to increased patient wait times. Furthermore, violence continues to be pervasive.[50]

In October 2023, OCHU/CUPE commissioned a Canadian polling service to survey HCWs regarding their working conditions.[51] It polled over 750 respondents, including RPNs, PSWs, housekeepers, clerical staff, food service workers, maintenance, and other hospital staff. The majority of respondents expressed dissatisfaction and negative effects on their mental health. Regarding patients, 69% overall disagree or somewhat disagree that there are enough staff to deliver high-quality patient care. The nurses were particularly affected by their work: 60.7% reported trouble sleeping; 36% suffer depression; 64.9% have anxiety; 75.4% experience high stress; and 55.9% dread going to work. When asked about conditions that might contribute to negative mental health effects, 43.6% of the nurses said violence had increased or somewhat increased since the beginning of the pandemic.

Neoliberal Health Care System Restructuring

We view the devolution of the Canadian health care system through the lens of the global neoliberal economic and

political restructuring, which has persisted since at least the early 1980s. Public health and health care policy researchers have expressed general aspects defining neoliberalism. These include privatization regarding property rights and social/government operations[52–55]; free markets[53–58]; free trade[53,56,57]; and deregulation/minimal government interference.[53–59]

In explaining neoliberal impacts on health care in Canada, researchers have focused on the imposition of austerity measures (decreased taxes on the wealthy, reduced support for public services, and reregulation of finance, increasing the wealth of the already wealthiest)[36,52,57–60]; a steady shift of the welfare state to the lean state and withdrawing rights to the social and environmental determinants of health as they become privileges for the more affluent[36,53,55,57–61]; and the removal of protective regulations for worker health and safety, environment, labor, and patients.[54,55,58]

The above summary of the Ontario and Canadian health care system restructuring matches the literature regarding the neoliberal structural reform of Canadian health care in the 1990s and 2000s, which resulted in rationalizing the provision of care and shifting services to private facilities while reducing the work force at public facilities.[36,52] This led to a public outcry about wait lists for some hospital and other medical services.[36,52] Hospitals were being closed or had services cut, and the number of beds was reduced.[59] The health care work force was reduced.[62] Hospitals began contracting some services to the corporate sector, and public–private partnerships (P3) became the common way to build new hospitals. This is the context of hospital work conducted by participants in our study.

Methods

A qualitative study[63,64] was conducted during the spring and summer months of 2023. The Research Ethics Board at the University of Windsor approved the study protocol (approval no.: 42781) on April 27, 2023. A literature review was conducted to ground the research and to frame the questions and analysis. Through confidential, anonymous individual interviews conducted via telephone conference calls, we explored the following questions: What are the effects of workload, overtime, and stress on the well-being of a select cohort of Ontario's hospital workers in todays' health care system, and how are these workplace conditions affecting their health and the quality of their work life and personal life? How do they perceive the current state of the health care system and the level of patient care it provides? What recommendations do they have for limiting the risks to their own well-being and those of their colleagues, and what quality of care can they provide?

Interviewees were recruited with the assistance of the OCHU provincial office. They were drawn from a range of hospital worker occupations represented by OCHU. Some were specifically invited because they had reported concerns, but an open invitation was made to any OCHU hospital worker who wished to be interviewed. Interviewees provided verbal informed consent before the interviews were conducted. The researchers were not given the interviewees' names or any other identifiers. Twenty-six hospital workers across Ontario were interviewed: 15 RPNs (who are referred to as nurses in this paper), 3 cleaners, 5 clerical staff, 1 physiotherapy assistant, 1 porter, and 1 PSW. Eighteen interviewees self-identified as women and 8 as men; 2 as LBGTQ+. Three self-identified as black or persons of color, 2 as indigenous, 2 as Asian, and the remainder as Caucasian; 3 were immigrants. Their work experience ranges from 3 to 32 years, and their ages range from 20s to 60s. The communities and facilities they work in range from small to large, most large, and urban. They work in a variety of departments. Because there is a history of employer reprisal against HCWs in Ontario who have spoken out publicly, identifiers have not been included with individual quotes to protect participants' identity further. This distribution reflects the ratio of the patient-facing occupational groups within OCHU whose members have expressed concerns about their mental health.

Interviewers used a conversational tone and asked open-ended questions.[65] Each interview lasted about 45 min to an hour, and all were audio-recorded and transcribed (see Interview Questions in the Supplemental Materials).

Data Analysis

Thematic analysis was used to explore the responses provided by interviewees to the semi-structured interview questions, providing insight into individual experiences and the contextual environment.[66] The recorded interviews resulted in approximately 250 pages of transcripts. Each of the 2 academic researchers who had conducted the interviews read through the transcripts, familiarizing themselves with the data and developed an initial set of codes. After removing all identifiers, they shared the initial coding system and a sampling of coded transcripts with the author representing OCHU. A few minor refinements were then made to the codes and they were shared with the fourth author for his input. After reaching consensus about the coding system, the two researchers who had conducted the interviews thoroughly re-read the transcripts and coded statements as they proceeded using select features in Microsoft Word, such as text highlighting for color-coding and comment insertion for recording notes and memos and for sorting. They added further codes as they were identified. A deductive approach was then used to organize the data under initial broad themes, and an inductive approach facilitated their refinement into subthemes. A final more detailed review was conducted[67,68] (see Themes and Sub-Themes in the Supplemental Materials).

Excerpts were chosen to exemplify the themes. The interviewees' own words (data) are used to convey their personal experiences and feelings.[69] Some passages were marginally

edited for clarity, brevity, or to protect the interviewee's identity, taking care not to alter the speaker's intent.

Results

The hospital workers we interviewed expressed dissatisfaction, stress, despair, sorrow, distrust, anger, and frustration. Several said they were being treated for anxiety; 1 was on mental health leave and 1 had recently quit. A palliative care nurse, whose job is by nature very emotionally demanding, talked about how her increased workload has made her already difficult job untenable:

> It's almost normal now to be short every day. It wasn't like this when I first started nursing. You can feel the stress when you get reports of the number of patients you're going to have that day…We're getting these complex patients. We're getting more and more responsibilities… My colleagues are crying. They're burnt out. We're calling in sick. We can't do all this care because it involves total personal care, washing them, dressing them. They are incontinent, they have catheters. Plus, you have to talk to the patients' families … it's reached a point where I'm going to be retiring as soon as possible.

There was an overarching sense of being increasingly unsupported, overworked, disrespected, and exploited. Most had lost confidence in the health care system and those managing it. Several were without hope of any positive change.

The results are organized under the main thematic headings of: health care system in crisis, deteriorating conditions of work, staff well-being, and future. Each theme has numerous subthemes as indicated by subheadings.

Health Care System in Crisis

The interviewees uniformly agreed that the Ontario health care system is in crisis, creating problems for workers and patients. A clerical worker said:

> Seeing the system, the way it is, I'm getting scared to get sick myself. Do I really want to come to my own facility? The exterior looks fine, but on the inside … everything's falling apart.

Change Over Time. While much has been written about the continuing erosion of the public health care system in Ontario, it is largely from the point of view of patients and their families. Hospital workers have seen first-hand the changes that have taken place over the last few years and the impacts these changes have on their patients, their ability to do their jobs effectively, and their own physical and mental well-being. An operating room (OR) nurse described how these changes have impacted their work:

> In the last four/five years it's gotten progressively worse. The work load has gotten heavier. They're taking away more staff and putting that work load on top of you. We're doing jobs of four different people … It's so unsafe, so unrealistic. It's an absolute disgrace to our profession.

A clerical worker told us of the lengthy decline in health care services and working conditions. She said: "We've been raising these concerns for over fifteen years. This is not new for us. We haven't just now started screaming we are understaffed, overworked, tired, we are underfunded and are being physically and verbally abused."

Wait Times. Interviewees stated that ER waits are egregious due to insufficient system alternatives, such as family doctors, urgent care centers, and after-hours clinics. Increased patient acuity puts additional pressure on scarce resources. An outpatient clinic nurse explained: "Health care itself has become more difficult because patients coming in have more health conditions, making their care more difficult. People are sicker. People have more mental health issues." Her opinion was shared by an oncology nurse who said: "… in the cancer center, patients are coming in sicker, putting off going to the ER, or they don't have a family doctor … we don't have enough space for the patients; there are more diagnoses happening now."

They explained that the conditions causing long wait times increase patient discomfort and potential risks and put extreme demands on the staff. An outpatient clinic nurse said: "We're always working short-staffed. We have a backlog of over two years. We hardly have time to take breaks or go to the washroom … I don't think patients are getting the care they need."

Insufficient home care services are a factor in ER backlogs. Regarding home care patients, a medical-surgical nurse explained, "There are not enough nurses in the home care system so they're coming into the ER. They're not spending their days at home; they're spending them lying in hospital beds with a nurse that has seven patients. There are more bedsores, and more medications are being prescribed."

A nurse described the effects of underfunding and poor planning on the availability of inpatient beds:

> Every single day I was going into work there would be twenty to forty no-bed admits … Individuals lying on a stretcher in the ER … They built a new facility, but the amount of beds we have now is lower than what we had. We don't have staff. They don't even have the budget for it.

The wait lists are also growing for elective surgeries and other hospital-based care. A clerical staff person said she understands the public's frustration: "Ontario's done really badly with our OR waitlists. They are months long. If … my dad was waiting six months on a list for an operation, I

don't know what I'd do. If it was my kid, honestly, I'd be angry too."

Waiting for care in under-resourced facilities impacts patient care and, potentially, outcomes. An OR nurse dismayed about the condition of patients entering the OR after waiting for days for availability, told us:

> We see individuals … who have been sitting in their beds for a day or two, sometimes three or four, because the operating rooms get so clogged. And when that individual gets to us they're so filthy, they reek of their own feces. The beds haven't been changed or the individual has not been properly turned and positioned. They're getting pressure ulcers, which a patient should never get in the hospital.

Interviewees reported the growing shortages of supplies and medication, taking patient care time to locate needed items. A medical floor nurse told us: "I get frustrated when I have to spend the first forty-five minutes of my shift looking for the lancets we use to test people's blood sugar – a crucial piece of equipment. I hadn't even seen my patients yet." An oncology nurse said: "Half the time our tools aren't there. We're missing supplies (and) medications."

Privatization. Interviewees reported their discomfort with and experiences of how health care privatization is straining patient care and worsening working conditions and HCW health and safety. The move toward for-profit health care changes its very nature.[58] The financial bottom line becomes a major focus. A clerical worker expressed her dismay regarding the encroaching privatization of many aspects of health care:

> I think health care has lost its touch. We've become less patient based … A corporation's main goal is to make money and the fact they can make money off of public health care is a real problem. Then it's not about health care anymore, it's about how can we continue to earn money while pretending to care about people? And I think that is morally wrong.

A nurse who has worked for over a decade and has taken pride in Canada's public hospital system worries current staffing shortages will be further exacerbated as private, for-profit agencies and care facilities proliferate:

> We already have a health care system. Why not just invest all that money you want to invest in the private system and put it back into the public system? … Where is the staffing going to come from? We can barely keep our hospital staff … staff(-ing) our hospitals in the public system and then in a private system … It doesn't make sense.

Interviewees discussed the higher wages and flexible hours provided by private nursing agencies as they recruit nurses from the increasingly arduous and understaffed public system. An OR nurse said: "Privatization is going to do one thing only. It will suck every single good nurse out of public healthcare … They will be very well paid, get the best hours, the best doctors … And that will leave you with a public system that is even worse off than it is now."

An obstetrical nurse described the increasing use of private agencies to fill gaps: "There are so many agency nurses working. It blows our mind when they pay them over $100 per hour and they don't want to pay our staff overtime. They tell us, 'We have no budget.'"

Conditions of Work

A high seniority nurse in postsurgical rehabilitation described a typical day: "You walk in and you're two staff down … So, my anxiety goes up because I won't get a break. No one cares … you're working short and there's so much stress."

The cleaning staff are concerned they are unable to properly do their job. We heard: "In the old days, it was more manageable and we could do a more thorough job. Now we're trying to get through all the rooms with fewer people. That's the challenge we have as environmental services, we've got more work than staff."

A clerical worker explained: "I can keep up but at the expense of my own sanity … I can keep on top of it if I really push myself and if I ignore everything else. But that shouldn't be the way it's done because then it's more like an assembly line than health care."

A nurse working on a medical floor described her workload: "You might have four patients, you might have seven. You might have a patient crashing and then you have six others screaming at you for something. And their family members!"

Many face irregular scheduling and demands for them to work overtime. A cleaner said: "Our phones never stop ringing being asked if we can come in and cover a shift. You can be leaving work and get a call before you even get to the parking lot asking 'Can you stay?' You can do that once in a while, but it's literally every day."

HCWs are also concerned about the risk of medical errors when the workload is unmanageable. A nurse working in a dialysis unit explained:

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

Retention. These negative working conditions seem to lead to an exodus of staff, contributing to further shortages and

related heavy workloads. An OR nurse said, "We have lots of nurses crying and lots of senior nurses quitting." A trauma-department nurse said, "A lot of our nurses left. Now our ICU is super short. There are fewer nurses to care for the patients coming from the OR and we are now backed up in surgeries." Another nurse worries the staff shortage will be exacerbated by the loss of new graduates who are unable or unwilling to put up with oppressive working conditions: "The newer nurses aren't coping well; they're leaving early. A number of my co-workers are on medication; a lot of them are the younger nurses."

A palliative care nurse wonders: "Why can't the government see it? It's just so obvious, it makes me tear up. I love my job but I can't wait until I retire and I'm only in my forties…There are so many nurses that did retire – seasoned, experienced nurses that are invaluable. All gone." An oncology nurse said the only thing keeping her on the job is financial necessity: "I know many [nurses] have just left their career … I wouldn't be here myself either if it wasn't that I have a family to support."

Wages. Most interviewees cited inadequate wage increases as a source of stress and frustration. A porter explained: "Inflation is at an all-time high. Mortgage rates are going higher. People have to work ridiculous hours to maintain payments." He said this leads to "burnout" and "contributes to their pessimism." A hospital clinic nurse agrees: "It's very disheartening to keep a positive outlook. You're constantly given more tasks, more responsibility, less compensation. Many nurses I know have quit because it's so hard on mental health and self-respect. Everyone is just so done."

An outpatient clinic nurse is particularly upset with the hierarchy within the system favoring those in upper management: "What really frustrated me was we were limited to a [small wage increase], but there was a manager in our corporation that got a 50 percent increase. That really hit me hard."

We were told there is tension between the two most common classifications of nurses—RNs and RPNs—who are often required to perform similar duties in understaffed hospital departments. The tension is due largely to a significant wage difference favoring RNs.[b] As a nurse explained:

> Because of the shortage of nursing staff, the RPNs are assuming those assignments that typically would be for RNs. I've got eighteen years nursing and I'm working alongside colleagues who are making twenty some odd dollars more an hour than me.

Another nurse told us: "I feel undervalued, unsupported, and way underpaid for the level of job I do, … it's starting to really affect me."

Gender and Race. Several of the HCWs we spoke with saw a connection between their poor working conditions and the gender and racial makeup of the work force. A clerical worker said: "I think a lot of it has to do with the fact that the majority of HCWs are women. We've been fighting for job equity for a very long time." A physiotherapy assistant told us: "I think it's gender, race, class, non-binary, and so on … but the common thread is we're women. And I believe we have to rip that page out of the book that if you're female you're supposed to take it. Enough is enough."

Violence. There are many reasons for violence. Patient frustration over wait times is one of them. A clerical worker explained:

> We've had an increase in (violence) … we're scared … The hospital has become so dangerous. It's dangerous because it's overcrowded and patients and families are frustrated with the system and the wait times. Who takes the brunt of it? The workers.

An oncology nurse agrees there has been an increase and said she is frustrated there seems to be no real consequences for the perpetrators:

> Violence in the hospital has increased since the pandemic … it takes a nurse longer to get to a patient now. And then that patient will get upset … You're allowed to be spit on, you're allowed to be kicked, punched, hit, sexually assaulted, there's no consequences. It's the only profession I've ever heard of where that kind of thing is allowed.

A dialysis nurse has had similar experiences and shares the frustration that violence continues to be seen as part of the job:

> I have been kicked in my chest. I've had needle stick injuries. I was told by management, "It doesn't matter. You go back to work." But if a cop got a needle stick injury from picking up a needle at a park, I think there would be a lot more attention than a nurse getting it on the floor … When I got that injury, we were short-staffed. I had a very troubled patient who had mental health issues … you're one person and you're rushing and you're trying to get things done … trying to keep your patients happy and you can't … we're tired, so tired.

Understaffing contributes to the risks for workers facing potentially violent patients. A nurse on a medical floor said: "We do not have enough staff. It's hard on us; it's hard on the patients. In the last two years, I've seen a lot more aggression from patients. I've been hit at least three times in the last six months. The families seem to be a lot more aggressive as well."

A clerical worker, often the first contact for patients, said: "It's a daily thing. You should see the angry voicemails we get. Or people come to the desk complaining they've tried

to call us for a week. It's mentally draining and it's disheartening; they're stressed and we're stressed."

COVID-19 Pandemic and Continuing Impacts. While there were pre-existing and now ongoing structural and funding deficits within the Ontario health care system, we learned the pandemic has caused significant additional stress for HCWs. Many have been left traumatized and exhausted. As an OR nurse said: "Even now, when we talk about the pandemic, people are still overwhelmed with what we've been through." Another nurse, who works on a medical floor said: "I'm very numb … along with the stress from the pandemic, I have kind of like PTSD. I'm definitely suffering from something … I pretty much put on the smiley face and keep going. That's what we're expected to do." A palliative care nurse told us:

> COVID brought out the worst. I was always a strong person and I'm a leader and I take on extra responsibilities but I couldn't handle COVID. I had to go on antidepressants … I was getting anxiety attacks getting off the elevator coming into my floor … I was so upset and distressed because I give my heart and soul to my work 100 percent. And I was just watching the injustice and it felt horrible to be so undervalued.

We spoke to a cleaner who broke down in tears as she described how she was doing during the early period of the pandemic and how she is still triggered thinking about it. She said: "Everybody was scared, it was stressful … I went to my family doctor and she knows where I work; she asked me how things were going. I told her, 'I need you to make note in my chart that I'm not doing very well.' I'm still not good." A clerical worker was diagnosed with post-traumatic stress disorder (PTSD) in the year prior to speaking with us. She explained: "I knew I wasn't okay. I was crying almost every single day. I thought I was going to be able to cope my way through, but I would spend two and a half of my four days off in bed."

A palliative care nurse described how the pandemic and its increased demands and stressors have been significant contributors to her moral distress:

> I was going into work, taking care of all of the patients, doing everything for them and overcompensating because they had no family [present]. They were depressed, which was making us depressed, watching the patients dying alone.

The high regard in which some members of the public held HCWs and the rhetoric the system used to help spur them on under grueling conditions may have helped somewhat in the early days, but the additional institutional supports they needed were not there. A clerical worker explained: "During the pandemic, everyone was suffering, so there was a drastic increase in the need for mental health services. Our patient numbers went up, but our supports did not. So as the numbers continued to grow, secretarial staff were not given extra support or extra staffing; they were actually cut to save costs." And as a nurse told us: "I don't think the public truly knows or understands what we as frontline HCWs had to deal with … No nurse has fully recovered. We're still stressed out, and we're still working short-staffed."

There has been little financial compensation or improvement to staffing levels and other working conditions. As a unit clerk said: "There's no time or resources or support given to help HCWs recover from the last three years … it feels like the government and our corporations are treating us as numbers, dispensable and disposable." Another clerical worker said: "We're heroes until we cost you money. So we have a saying at the hospital, 'We sure went from hero to zero really fast' … And they wonder why morale is low." Another said: "We were heroes until we became a strain on the budget … we're doing our best, but it isn't good enough; we can't continue down this path without extra staff." A medical floor nurse said:

> I got tired of hearing we were the heroes, and you can't pay us appropriately. It's okay for patients to hurt us. I had to wear the same N95 mask for 16 hours … Now we know what COVID is and what we're dealing with. But now there are all these other stressors, and everybody is burnt out; they're calling in sick.

A PSW had a similar experience. After becoming ill, likely from exposure to a patient at work, she was denied workers' compensation despite her ongoing health problems:

> I was off for a year and a half … I'm still having effects, low O_2, loss of memory … when it started they were only allowing us two masks per shift. We had to sign them out like we were criminals … They were saying we must have got sick from going to the gas station or the grocery store.

A trauma-department nurse explained the current conditions of work and dearth of supports allow for little recovery: "We are still experiencing the trauma from COVID on a daily basis. We're still trying to catch up. We're still living horrors we went through, and there's just nobody there to help. You just feel alone." A palliative care nurse told us: "I have depression and anxiety. I never had it before COVID – the increased duties, staff vacancies … the added work really affected me. I'd come home and needed days to recover from my shift. I would cry. It affected my relationship with my husband."

A clerical worker sees the way HCWs have been treated during the pandemic as part of a broader societal problem: "COVID highlighted a lot of the disparities we have in our society, and it made it seem so unjust, especially in public

services. It's hard to feel like part of a loving and productive society when you see all of these terrible things happening."

Staff Well-Being

Stress. Increasingly stressful working conditions were highlighted by many interviewees. A dialysis-department nurse said: "The nurses are having crying fits and not being able to finish their day because they just feel so overwhelmed."

For some, flight seems to be the only solution. A trauma-department nurse told us: "I literally think every day how can I get out of this? I don't want to be here anymore … I've known nurses to take their own lives. The stress got so bad a lot of our ICU nurses got PTSD. And there was nobody there to help them."

Others depend on medication. A palliative care nurse said: "I have to depend on antidepressants because of the new normal at work and all the increased duties and the stress. I can't cope." A nurse working on a medical-surgical floor told us: "A number of my co-workers are on medication. I had to go on stress leave. A couple of my nursing friends have been on stress leaves. A lot of us have thought about quitting. You can work at Costco and make almost the same amount of money."

Burnout. An outpatient clinic nurse said: "Just on my floor, out of about twenty-five or thirty nurses, we've had at least six burnouts in the last year. I was one … I underwent a massive depression, just not feeling like I was enough for anybody and, especially financially, I just figured I was worth more dead than alive." A former inpatient floor nurse explained why she transferred to outpatient work: "I really loved the particular unit I was on for many years … but they started to not replace any sick calls so we were always short … And then they took away a nursing line altogether, permanently, so it just added to the stress."

A relatively young medical floor nurse described her working conditions and how they are affecting her well-being and her ability to provide care:

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

Overwork and stress can lead to debilitating exhaustion. An oncology nurse noted even "our patients comment about how tired we can look." Another oncology nurse told us how stress disturbs her sleep and can affect her work. "Some days I was coming home after a nightshift and I just couldn't get any rest. I was very stressed from the shift so I'd get maybe a couple of hours sleep and then have to go in the next day."

Another nurse said she would not sleep well the night of our interview because she was due to start a new rotation the next day: "I'll be panicky all night because I'm not sure what I'm walking into." A palliative care nurse explained: "I have insomnia because I'm thinking about patients and work and feeling guilty and sad. I have to take sleeping pills, which I never had to do before … I'd come home some nights and I'd just cry."

The lack of staff, particularly in critical care situations, can have traumatic effects on the remaining staff. A clerical worker told us about an event that left her emotionally scarred:

> I've been getting more flashbacks … The doctors are in there pumping on a man's chest, but the cleaner and I are outside the room holding the man's wife so she doesn't crumple to the ground while she's watching her loved one die. It's us doing those things because the hospitals don't have social work on every day.

Moral Distress. As indicated previously, one of the major contributors to poor mental health among HCWs is moral distress or moral injury. A nurse who moved from a medical floor to dialysis disclosed: "I'm not even proud to be a nurse anymore … I used to be excited about the patient's outcome … Now I just want to do my job and go home."

A nurse who experienced burnout stated: "Nursing care is not just the medical aspect, it's also the personal care … providing emotional support is as important as providing medical support." A physiotherapy assistant explained:

> The personability of health care is gone. So much documentation is needed; we're becoming more robotic and not as personal … it's very hard to say, "I'm sorry, I have to go" … It's always in the back of your mind, how much time do I spend with this person and try to console them?

Clerical staff can face moral dilemmas presented by demands: "I can't build rapport with patients and also make sure each one is dealt with in a timely manner. It's impossible … If I take more time with each individual patient, the ones waiting for service are waiting longer. It's a trade-off. What am I supposed to do?"

A palliative care nurse is disturbed her role has been so circumscribed by staffing shortages:

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

A palliative care nurse from another facility is experiencing similar unease about her inability to do her job effectively:

> They've cut me up into pieces. They spread me so thin I don't have the time to provide the level of care I would love to provide. And the anxiety and the guilt, and the feelings I should've done more, but I can't; I can only do so much. …Palliative care is hard enough. And then with the issues we have at work and the concern about patient neglect and the physical part of the job is so draining … my job is killing me.

Personal Life. A healthy work–home balance can be difficult when working conditions leave staff strung out, anxious, and/or exhausted. A clerical worker told us, "I don't stop, from the moment I walk into work to the moment I leave … And so many of my co-workers say the same thing. We have nothing left by the time we get home … You just eat, live, and breathe the hospital, and you just hate it."

A clerical worker from another facility described how she feels once her shift has ended: "I come home, and I'm usually too exhausted to do anything else that day … more often than not, I don't have the capacity to have much of a conversation with anyone. My friendships have suffered, my relationship with my family has suffered." A dialysis nurse affirms work stresses and exhaustion can affect personal relationships: "We're bringing our frustrations home … Or we just come home so tired, we're falling asleep all the time. And there isn't that building of a relationship anymore. You have no home life." A medical floor nurse described how her mood and ability to interact with family members are impacted: "My husband has said to me, 'You're not as patient at home as you used to be.' I try not to, but I absolutely do bring it home with me." A clerical worker said: "Now we're having to do double the work just to try not to get too backlogged. And it's really put a strain on workplace dynamics and relationships at work, and we are taking it home at the end of the day."

Some HCWs have the additional challenge of securing adequate child care. A cleaner spoke of a new coworker who suddenly quit because he needed to be home with his child after his wife found a job that paid more than his. A medical-surgical nurse with children talked about the difficulty in arranging child care when they cannot be in school. She said, "Who's going to watch them? I have to go to work. And the corporation is saying they don't care if I have kids at home. I have to come in."

Future

Study participants discussed challenges the increasing HCW shortages pose to staff. A palliative care nurse, exhausted by her job's increasing demands and disheartened by her inability to provide adequate care, told us: "Having been a nurse for eighteen years, I would not recommend anyone take the nursing program. And it's unfortunate because I love what I do – I've loved what I've done, I guess. But now it's so draining and so tiring."

Another palliative care nurse expressed fear: "There's going to be increased death rates, infection rates; people aren't going to be getting looked after properly and it's going to spiral out of control." She said: "In fact, it's already happening!"

Regarding the future of health care in Ontario, a nurse working in general medicine said:

> I fear for so many people; I fear for myself. Financially, [a for-profit system] is not feasible for the majority of people … How are my children going to afford health care in the future? We're already seeing cancer patients waiting for treatment or waiting for surgery but are passing before that time comes.

What Needs to Change. Unfortunately, many of the HCWs who participated in the interviews felt discouraged to the point of hopelessness. A majority were grateful to their union for its efforts, and some had taken part in collective actions, such as rallies and campaigns. But most felt positive changes were not likely to take place … As a clerical worker said: "I haven't seen anything that gives me any hope." An OR nurse explained their options are limited by legislation prohibiting HCWs from striking: "The government has scared us so much saying you can't walk out. There's no way to strike. There's no way to have your voice heard … HCWs have no hope any more."

When asked what changes are needed, the responses were almost universal: increased *funding* for the public system, more staffing, better wages, more manageable workload, more equitable treatment of workers, a change in the allocation of funding that includes fewer management and less exorbitant chief executive officer salaries, greater protections from violence, more respect from managers, and improved mental health supports. These detail what neoliberal health care restructuring stripped from Ontario hospital workplaces. A palliative care nurse said: "We need more front line workers. We need better funding. We need people to be the priority over money. If you don't have any staff, you don't have any health care." An OR nurse said: "There's a lot of division in health care … It needs a lot more communication. There needs to be a lot less management and a lot more talking between the provincial and federal government with a lot more money flowing into the health care system." An oncology nurse stated: "The public needs to know without better working conditions and more nurses, the system is never going to recover."

Discussion

The experiences reported by the HCWs who took part in this study, along with polling from various HCW and policy advocacy organizations, highlight the increasing burden of stress and burnout among Ontario's hospital workers and the accompanying staff retention problem. The anguish and anger expressed by the interviewees were palpable. The mental health of the work force is characterized by anxiety, sadness, a dread of going to work, and a sense of hopelessness. Most of the HCWs who were interviewed did not articulate a broad social or political analysis but did flag increasing work stressors in their own facilities as determinants of their declining well-being.

A multiplicity of health care work stressors has been well documented and discussed internationally for over a decade.[70–72] Violence against HCWs is epidemic.[25,26] Although HCW unions and professional organizations have been negotiating and lobbying for protective changes for decades, violence against staff continues. Verbal abuse, including racist and sexist remarks, along with physical assaults, adds enormously to stress. Even the anticipation and fear of abuse are stressful. High emotional and physical demands, lack of control, and inadequate support, the underpinnings of workplace stress,[73] along with such social determinants such as gender, race, and immigration status, all contribute to compromised mental health.

Extended stress can result in burnout, and according to the US Office of the Surgeon General results from: "… inadequate support, escalating work loads and administrative burdens, chronic underinvestment in public health infrastructure, and moral injury from being unable to provide the care patients need."[74] Some HCWs have even contemplated or died from suicide related to occupationally related stress.[75,76]

Besides the negative effects of the current conditions on the interviewees' well-being, the picture they paint of the deficiencies and even dangers presented by the erosion of the health care system also raise serious concerns for population health and medical care. It was remarkable how closely their experiences and concerns are reflected in the growing body of literature regarding HCW mental health.

While many interviewees largely held their own hospital's management to blame, others understood there were forces at play well beyond the institution employing them. Interestingly, many HCWs referred to the hospitals where they work as "corporations," reflecting increasing corporatization and privatization of the system and use of corporate management protocols for public health services. Some described situations in which smaller local public hospitals had been closed and replaced by large P3s, which, in reality, provided a reduction in the total number of beds.

Interviewees also characterized the power relations within the management and staff structure as increasingly top-heavy, seemingly heartless, and more disengaged from the day-to-day challenges facing staff and the realities of patient care. Present-day management structures and practices prohibit much of the self-directed nature of health care work.

They described in no uncertain terms that patient wait times had corresponding negative effects on staff well-being. Wait times elevate staff stress and the risk of abuse or violence from disgruntled patients and loved ones. But, as care providers, they also understood how unpleasant and even dangerous the wait times can be for patients. These realities compound HCWs' moral distress as their ability to provide appropriate patient care is increasingly restricted.

The less highly paid HCWs are in a disadvantageous position within the hierarchical structure of their workplaces. For example, RPNs are being required to do much of the same work as the more highly paid RNs but have less decision-making power. Moreover, 4 out of 5 HCWs in Ontario are women,[36] and many are racialized.[77] Social inequalities related to gender, race, and social class put them at a distinct disadvantage when it comes to influencing change. Katherine Lippel explained this phenomenon as "structural violence," a term used:

> … to identify the heavy work loads, low levels of decision-making autonomy, low status, rigid work routines and insufficient relational care as forms of violence. Not only are these poor working conditions experienced as sources of suffering, but they prevent care workers from providing the kind of care they know they are capable of.[78]

The interviewees' experiences reflect a broad undermining and destruction of Ontario's once-prized public health care system, shattered by neoliberal restructuring and increasing privatization. This trend toward privatization begs several questions: How has Canada's health care system been allowed to slide from a world-class public system into an under-resourced and inequitable quagmire? And how has it evaded comprehensive public scrutiny and remonstration? Pat and Hugh Armstrong, who have studied aspects of Canada's public health care system throughout their academic careers, offer the following explanation:

> It has been called privatization by stealth…The complexity of Canada's federal system that leaves much of the responsibility for health care to the provinces and territories has helped to hide these developments… Such subterfuge has been necessary because health care has long been Canada's most popular social program. This steady privatization has had serious consequences for access to and support for the public health care system while embedding profit and for-profit managerial techniques in health care services.[36]

HCWs, their unions, and the public want accountability for the policies that deeply reduced the high-quality, accessible, and affordable health care services in Canada. This is more easily said than done. A HCW groundswell is emerging

but is still limited. This is due in part to legislation banning HCWs in Ontario from striking. However, as we heard in some of the interviews, there is also a sense of hopelessness that causes a kind of paralysis. This can be seen as a form of "learned helplessness."[79] This phenomenon was outlined in 1970 by psychologist Martin Seligman. He hypothesized it could lead to depression and inertia and suggested: "people repeatedly exposed to stressful situations beyond their control develop an inability to make decisions or engage effectively in purposeful behavior."[80]

Public dissatisfaction and awareness of the problems within the hospitals and health care system are increasing. The frustrated public and the exploited HCWs are finding common ground and amplifying each other's demands, and there are growing public campaigns demanding improvements to Ontario's public health care system.[81] A 2023 CCPA report recommends: "…the provincial government rethink its plans for the significant expansion of for-profit surgical and diagnostic delivery and, instead, refocus efforts on public system improvement …."[35]

Multiple Canadian and Ontario HCW unions and other organizations representing medical professionals have since spoken out loudly about health care conditions in the media, social media, and editorials and have sponsored rallies and campaigns to lobby the government and influence the public. Five HCW unions—CUPE, SEIU, Unifor, Ontario Public Service Employees Unions, and the Ontario Nurses Association (ONA)—sent an open letter in early 2024 to the prime minister and federal ministers saying privatization "…puts their members and those they care for at risk and want the federal government to consider that when negotiating Canada Health Transfers" to the provinces.[82]

Necessary Action for a Just Health Care System

When considering the breadth of evidence produced by researchers across the globe, along with this study's findings and the statistical data we reviewed, we concur with the interviewees there is a critical need for policies and legislation ensuring increased funding, additional staffing, increased hospital capacity, reduced wait times, mental health supports, fair HCW wages, predictable scheduling, greater respect and acknowledgment, and strong protection from abuse, violence, and other health and safety hazards. Regarding equitable wages, value is intrinsically tied to salary in a capitalist society. With real wages falling, many HCWs, the majority of whom are women, feel undervalued.

The findings of this study support the demands made by a coalition of Ontario health care unions which issued a 5-point plan to "begin to turn around the system crisis, staff up our hospitals and stop emergency room closures."[83] They called on the government to increase staffing, provide mental health supports, increase safety for staff and patients, increase full-time positions, provide on-site child care, increase wages and provide "financial incentives" to encourage new employment and retain existing staff, give staff the opportunity to "…work additional shifts when safe for them to do so,…" offer incentives in order to recruit additional licensed HCWs, "expand post-secondary spaces for health disciplines," and "…waive tuition and provide additional financial incentives to study and practice in Ontario."

Improved nurse–patient ratios, as implemented in the province of British Columbia,[84] would help to alleviate burnout, thus reducing attrition and improving the quality and timeliness of patient care. Such ratios already exist, for example, in California and Australia.[85]

Restoration and expansion of Ontario's (and Canada's) health care system will require a social, political, and economic transformation at least as all-encompassing as neoliberal restructuring has been since the late 1970s. For HCWs, that will require building much greater power for their union and the labor movement in solidarity with the broad range of social justice movement sectors.

The World Health Organization's (WHO) 2021 Geneva Charter for Well-Being was written following the decades of global neoliberal entrenchment and the economic and social devastation of the 2007–2008 Global Financial Crisis. The charter addresses the "Foundations of Well-being to establish 'well-being societies'" that will require coordinated action in 5 areas. Two were: "Develop Healthy Public Policy for the Common Good" and "Achieve Universal Health Coverage." It called for the actions to be globally supported by "sustained investment in health-care workers, health promotion, public health infrastructure and research."[86] Additionally, the outcome statement from a 2023 WHO European health system conference stated that for health systems to resiliently and sustainably meet population challenges, they must show HCWs that: "… their work, their careers and their well-being are valued."[87] Our study participants made that clear in their statements.

There are limitations to the study. The interviewees were all members of a segment of HCWs whose occupations placed them within the membership parameters of OCHU/CUPE. As a result, some health care occupational groups, such as RNs, physicians, and surgeons, are not included. The opinions, experiences, outlooks, and health problems of the 26 interviewees may not fully capture those of the many thousands of HCWs in other jurisdictions nor those in other occupational groups.

Conclusion

The findings of this study are consistent with the expanding body of scientific literature supporting the contention that the well-being of HCWs is declining and austerity-driven government policies are major contributors. Together with the polling data we examined, and the attrition data from Ontario hospitals, this study reveals a work force at the limit of its ability to cope. Both a mental health crisis over

the conditions of hospital work and a moral crisis over patient care quality are unfolding. This has led to an unprecedented exodus of care givers. As future population growth and aging combine to surge against an under-resourced Ontario hospital system, all signs point to attrition rates accelerating. Workloads for those who stay will be impossible. If, as Pat Armstrong asserts, the conditions of work are the conditions of care, then society should be truly alarmed by this crisis, its implications for the work force and the quality of care that hospital patients receive. Energetic measures to moderate workloads across the hospital work force, including nurse-to-patient ratios, are urgently required to support HCW well-being.

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Supplemental Material

Supplemental material for this article is available online.

Notes

a. A detailed overview of the Canadian system can be found at the Commonwealth Fund's website, https://www.commonwealthfund.org/international-health-policy-center/countries/canada.
b. Since 2005 RNs in Ontario have been required to have a 4-year university degree while RPNs need a 2-year practical nursing diploma.[88]

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