HRTO FILE 2013-16149-I

HUMAN RIGHTS TRIBUNAL OF ONTARIO

ASSOCIATION OF ONTARIO MIDWIVES

Applicants

v.

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTER OF HEALTH AND LONG-TERM CARE

Respondent

AFFIDAVIT OF THERESA AGNEW

I, Theresa Agnew of the City of Toronto in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I am a registered Nurse Practitioner and the Executive Director of the Nurse Practitioners' Association of Ontario (NPAO). As well, I have experience working in Community Health Centres in Ontario during the period 1986 - 2012. My background, knowledge and experience which support the statements in this Affidavit are set out in my Curriculum Vitae1 and summarized in Part 1 below

2. This affidavit constitutes the main section of my examination in chief in this proceeding.

TABLE OF CONTENTS

1 Theresa Agnew Curriculum Vitae (2015) AOM0016129.

I. BACKGROUND:

1. Education and Knowledge

3. My educational background ranges from receiving my Primary Health Care Nurse Practitioner Certificate from Ryerson University in 1999 back to my initial Registered Nurse Diploma from the Ryerson Polytechnical Institute in 1981.

4. In between, in 1983, I completed a Bachelor's of Arts in Social Development Studies at the University of Waterloo and returned to Ryerson Polytechnical Institute to complete a Bachelor of Science in the Nursing, Child and Family Stream in 1989. In the early 1990s I completed my Masters of Science in Nursing coursework.

2. Clinical Practice

5. As a primary health care nurse practitioner, I have worked in a variety of health-care settings including hospitals, university health services, northern nursing stations, but primarily in Community Health Centres ("CHC"). My clinical work has had an ongoing focus on improving healthcare outcomes for mothers and babies through initiatives including breastfeeding promotion and perinatal

programs. As a result, I have interacted with family physicians, obstetricians and midwives with respect to maternal and newborn care.

(a) Hospitals

6. From the period 1981 to 1984, I was a staff nurse in the department of cardiology and spent two years in the paediatric emergency department at the Hospital for Sick Children in Toronto. From 1984-1986, I was the Patient Representative reporting to the CEO at that hospital.

7. I also completed a 12-week rotation in an adult emergency department as an NP at the Scarborough Grace Hospital in 1990, where I performed tasks such as leading resuscitations, performing minor surgical procedures, and suturing wounds.

(b) University Health Services

8. I worked as the Manager, Campus Health Services at Ryerson University from April 1998 – 2001, where I managed a staff, including physicians.

(c) Community Health Centres

9. Starting in 1986, I worked at York Community Services Community Health Centre as a Primary Care Nurse/Nurse Practitioner. While there I designed and implemented the *Food Experience* and *Mother's Health Action Program.*

10. From 1989 to 1992 I worked as a senior Community Health Nurse at Lawrence Heights Community Health Centre in Toronto and reported to MOHLTC witness, Sue Davey who was the Executive Director. In that role, I worked to expand the role of the primary care nurse, initiated a comprehensive, perinatal program and coordinated a health survey of the community.

11. Between 1992 and 2001, I worked as a locum Nurse Practitioner (NP) at various CHCs including Davenport Perth CHC, Four Villages CHC, and LAMP CHC.

12. From 2001 to 2012, I was a Primary Health Care Nurse Practitioner at the East End Community Health Centre in Toronto. In this role I provided primary care services to individuals and families in the context of a multi-cultural, low-income community.

(d) Northern Nursing Stations

13. In 1989 I worked as a Primary Care Community Health Nurse in Moose Factory.

3. University Teaching and Scholarly Work

14. I have worked as a part time sessional Instructor at Ryerson University in the School of Nursing from January 1991 – June, 2001 teaching a variety of courses

including in the Primary Health Care Nurse Practitioner Certificate Program. In that role, I assisted in developing the core competencies for the Nurse Practitioner Program of the Consortium of University Programs in Nursing – Primary Health Care (COUPN-PHC) in 1994 and 1995 while I was working as an instructor at Ryerson University.

15. I have written and presented extensively on nursing issues as set out in my Curriculum Vitae including: professional integration, the development of the Nurse Practitioner role and maternal care. For example, “Nurse Practitioners in North America: Progress and Challenges", June 12, 2001 Presentation to the International Council of Nurses, Copenhagen.[2] I also co-authored "Breastfeeding Curriculum for Undergraduate Programs in Health Care."

4. Nurse Association Roles

16. Between 2002 and 2005, I was President of the NPAO and worked unsuccessfully to negotiate a contract with the MOHLTC with respect to Nurse Practitioners.

17. In 2012, I became the Executive Director of the Nurse Practitioners’ Association of Ontario (NPAO), which has approximately 2200 members. The NPAO is responsible for government relations and negotiations; professional development and membership services; and representation of non-unionized Nurse Practitioners in Ontario. I report to a Board composed of 16 Nurse Practitioners from across the province. I frequently consult with other major health care provider representatives, including the Ontario Medical Association, the Association of Ontario Midwives, the Registered Nurses Association of Ontario and the Ontario Nurses Association.

18. From 2011-2012, I also served the NPAO as the Member Relations Coordinator. During that period I acted as a liaison between the members, the Association executive and the Board of Directors by responding to members’ questions, summarizing current issues and problem solving. I also developed NPAO responses to federal and provincial policy initiatives and developed and delivered presentations to senior staff within the provincial government.

19. Prior to this time, I was a member of the Board of Directors of the Registered Nurses’ Association of Ontario (2008-2010).

5. Ontario Health Care System Roles

20. I have been involved in policy development regarding the Nurse Practitioner role in Ontario from 1994 until present. I played a key role in developing the Nurse Practitioner role in Ontario by assisting in the initial grandfathering process for

2 Theresa Agnew Curriculum Vitae, (January 1, 2015), AOM0016129.

Nurse Practitioners. I received the Queen's Diamond Jubilee Award in 2013 for my work in this regard.

21. I was appointed by the Minister of Health and Long Term Care to be a member of the Nurse Practitioner Implementation Task Team in 2004. This team was to work on implementing the recommendations of the 2003 IBM Report commissioned by the MOHLTC, which had made recommendations on the further integration of nurse practitioners in Ontario.[3] I was also appointed by the Minister to the board of the Ontario Family Health Network from June 2001 to July 2004 as well as the Family Health Team Action Group from 2004-2006. The Family Health Networks became Family Health Teams.

22. I have also acted as a peer assessor for the Quality Assurance program for the College of Nurses of Ontario (2010 – 2011). As a peer assessor I reviewed learning plans and test results of Nurse Practitioner registrants and prepared reports for the CNO Quality Assurance Committee. As well, I conducted practice audits and site visits to assess registrant performance and compliance.

23. As Executive Director of NPAO, I led the response of the NPAO to the MOHLTC's Action Plans for Health Care, which started in 2012 and continued with the NPAO's response to the MOHLTC release in December, 2015 of their *Patients First - A Proposal to Strengthen Patient Centred Health Care in Ontario MOHLTC* Discussion Paper. [4]

6. MOHTLC Work

24. I worked with the MOH from 1990 to 1991 as a Research/Technical Advisor in the Women's Health Bureau, advising on a wide variety of women's health issues, including the development of the nurse practitioner role. In December of 1994, Minister of Health Ruth Grier announced that there would be legislation creating a nurse practitioner or extended class of nursing.

II. NURSE PRACTITIONERS, MIDWIVES AND PHYSICIANS

1. Many Overlapping Health Care Services

25. As set out in this affidavit, Nurse Practitioners, Physicians and Midwives are all primary care health care providers who share the provision of health care in many important ways. Primary health care providers are those who provide first-contact assessment of a patient and the provision of continuing care.

---

3 Report by IBM Business Consulting Services re: Integration of Primary Health Care Nurse Practitioners in Ontario, (June 30, 2003), AOM0000865.

4 Patients First - A Proposal to Strengthen Patient Centred Health Care in Ontario, December 17, 2015, MOHLTC Discussion Paper MOH004930.

26. Since the 1980's, Nurse Practitioners and midwives have increasingly taken on health care responsibilities and scopes of practice which were previously reserved to physicians in the health care system.

27. Nevertheless, as set out further in this affidavit, in my experience, there is generally a hierarchical structure within the health care system, with physicians at the top. In my experience, physicians are accorded power and privileges that are not accorded to other health professions, including Nurse Practitioners, in spite of their importance to the health care system's reform objectives.

28. Despite the fact that NPs are taking on providing health care that is or was performed by physicians, such health care services are not remunerated in a way that properly recognizes those contributions. In fact, the more that I have observed NPs taking on those responsibilities, as set out in this affidavit below, the larger the pay gap has become.

2. Similarities between Female- Dominated Nurse Practitioners and Midwives

29. Similar to midwives:

(a) Nurse Practitioners are highly female predominant. There are 2900 NPs in Ontario currently. In 2011, 94.8% of registered nurses and 95% of NPs in Ontario were female.[5] As of 2014, the female predominance of NPs was reduced by only 1% to 93.9%.

(b) Nurse Practitioners provide high-quality and cost-effective primary care in areas traditionally reserved to physicians.[6]

(c) Nurse Practitioners' distinct knowledge and care are on an equal footing with physicians in many respects and in a number of aspects produce better outcomes.[7]

III. NURSE PRACTITIONER PROFESSION

1. Introduction

30. Nurse Practitioners are advanced practice Extended Class registered nurses with additional knowledge and skills that build on the broad, generalist health science

---

5 Report - Canadian Nurses Association - 2010 Workforce Profile of NPs in Canada, (November 1, 2012), AOM0000662.

6 Article from BMJ online Medical Journal re: Systemic review of Cost-effectiveness of nurse practitioners in primary and specialized ambulatory care, (June 8, 2015), AOM0016145.

7 "Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors," Horrocks S et al., *British Medical Journal*. 2002 Apr 6; 324 (7341): 819-23. See also Article from BMJ online Medical Journal re: Systemic review of Cost-effectiveness of nurse practitioners in primary and specialized ambulatory care, (June 8, 2015), AOM0016145.

education of registered nurses in the general class (Registered Nurses). Like midwives, their work spans the work of medicine and nursing. [8]

31. Nurse Practitioners work in direct care, health promotion and the treatment and management of chronic health conditions. They have an expanded scope of practice and can diagnose, order and interpret diagnostic tests, prescribe medications, and perform certain procedures.

32. The *Expanded Nursing Services for Patients Act* was proclaimed in 1998 following 25 years of lobbying. This marked the beginning of a formal process enabling nurses to be registered with the College of Nurses in a new "Extended Class" encompassing additional authority to perform controlled acts and other aspects of practice not authorized to nurses registered in the general class.

33. The complexity of health care legislation necessitates ongoing consultation, collaboration and support from many groups in a variety of settings to remove the remaining barriers to NP practice to achieve full integration of NPs in Ontario's health care system.

2. History

34. NPs started formally in the late 1960s in Ontario (many nurses working in Northern and outpost areas has an overlapping scope prior to this) when in 1967 Dal Housie University set up an educational program for NPs followed by six other universities in Canada.

35. In the 1970s educational programs became available to registered nurses in order to gain additional or "extended" responsibilities. However the "extended" nursing roles were not regulated or funded.

36. In the early 1980s, the first NP initiative ended because of perceived physician oversupply, lack of remuneration mechanisms, lack of legislation and a lack of public awareness regarding the role and lack of support from both medicine and nursing. The last NP education program closed at McMaster University, Hamilton, Ontario in 1983.

37. Despite these barriers, approximately 250 NPs continued to work in Ontario throughout the 1980s and early 1990s, primarily in Ontario's Community Health Centres as I did.

38. In spite of the failure of the first initiative, the NP role was consistently cited in the recommendations of many provincial health care commissions and task forces as

8 Report by NPAO re: The RN Role in a Community-Based Primary Health Care Practice, (April 1, 2000), AOM0002403.

an important contributing profession to health care reform.[9] The NPAO continued to actively lobby to re-establish educational programs in Ontario and for the recognition of the NP role as a viable member of the Ontario health care system.

39. When I first began working in CHCs the formal designation of Nurse Practitioner was not recognized although it was informally used in some workplaces. At that point the titles "Senior Primary Care Nurse" or “Nurse II” were also generally considered to be the equivalent to what we would call a Nurse Practitioner today. Ontario’s *Nursing Act, 1991*, also recognized registered nurses in the extended class, now also called Nurse Practitioners.

40. In December 1994, Health Minister Ruth Grier introduced the Regulated Health Professions Act,(RHPA) that provided the regulatory and legislative authority for the Nurse Practitioner scope of practice. I was at the LAMP CHC when Minister Grier made the announcement to formally reintroduce Nurse Practitioners in Ontario. At the time, she noted that Nurse Practitioners as well as midwives would now be regulated health professions.

41. In December 1994, the MOH document *"Nurse Practitioners in Ontario: A Plan for their Education and Employment of NPs"* was released with specific steps for implementation.[10] That document proposed a salary range of $60-80,000 per annum. By 1995 the CNO referred proposed legislation changes to the Health Professionals Regulatory Advisory Council (HPRAC).

42. Beginning in 1994, many NPs, including myself, were instrumental in creating new initiatives with the Ministry of Health and Long Term Care as part of government’s primary health care reform strategy. This resulted in the re-establishment of NP university education programs in 1995 and the *Expanded Nursing Services for Patients Act* which was passed in 1998. This legislation gave NPs registered in the extended class with the College of Nurses of Ontario (initially primary health care NPs) the authority to practice within a broader scope of practice which included three additional controlled acts: communicating a diagnosis, prescribing a limited range of drugs, and ordering certain tests, x-rays and ultrasound.[11] Nurse Practitioners now had an overlapping scope of practice with both medicine and nursing.

3. The Role of the Nurse Practitioner

43. Nurse Practitioners (NPs) are registered nurses with an expanded legislated scope of practice. NPs deliver nursing and medical care at an advanced level to

---

9 Report of the Task Force on the Implementation of Midwifery in Ontario (TFIMO), (January 1, 1987), AOM0013549.

10 Nurse Practitioners in Ontario: A Plan for their Education and Employment of NPs, Ministry of Health, December 1994. AOM0017395.

11 Website by Nurse Practitioners Association of Ontario re: Nurse Practitioner History in Ontario, (August 25, 2014), AOM0000855.

specific patient populations in a variety of health care settings. All NPs in Ontario are now registered in the Extended Class with the College of Nurses of Ontario as one of three NP specialities: NP-Primary Health Care, NP-Adult and NP-Pediatric. Within each of these broad areas of specialization, NP practice may be broad or narrow in focus depending upon the needs of the patient population in specific practice settings coupled with the knowledge and experience of the NP.

44. Nurse Practitioners take a holistic approach to care, addressing not only symptoms but also the patient's emotional response, facilitating connections with community resources and putting an emphasis on health promotion and social determinants of health (the "bio-psycho-social").

4. Entry Requirements for Nurse Practitioners

45. To become registered in the extended class (as Nurse Practitioners) in Ontario by the College of Nurses of Ontario, registered nurses must meet the following registration requirements:

(a) demonstrate at least two years of safe nursing experience over the past five years – including one year in an advanced nursing practice role (one that requires use of advanced knowledge and decision-making skills in assessment, diagnosis and health care management);

(b) have graduated from an approved NP education program,

(c) have passed a regulatory exam, and

(d) be registered, or eligible for registration, as a registered nurse (RN).

46. However, in practice, the average NP works for 16 years as a Registered Nurse before returning to school to complete a Master's Degree or post baccalaureate certificate to qualify as an NP.[12]

5. Education

47. The Council of Ontario University Programs in Nursing (COUPN) established the Ontario Primary Health Care Nurse Practitioner (PHC NP) Programme in 1995. This Affidavit focuses on Primary Care Nurse Practitioners.

48. Ryerson's Primary Health Care Nurse Practitioner (PHCNP) Certificate is an intensive Masters of Nursing program that prepares nursing professionals to write the College of Nurses of Ontario's NP – Primary Health Care (Ontario) exam. Admission to Ryerson's PHCNP Certificate program is highly competitive.

12 Nurse Practitioners Association of Ontario Report: Toward a Primary Care Recruitment and Retention Strategy for Ontario: Costing Analysis for Ontario's Interprofessional Primary Care Organizations, (January 6, 2013), AOM0015465.

The PHCNP Certificate program is offered under the Council of Ontario University Programs in Nursing (COUPN).

49. Nurse Practitioners have additional knowledge and skills that build on the broad health science education of registered nurses in the general class. Their training equips them to independently perform many of the diagnostic and treatment functions within the purview of physicians.[13] At Ryerson, the PHCNP program is full-time and requires the completion of seven courses, typically completed over nine terms (two full calendar years). It includes 750 hours of clinical practice.

50. The Canadian Nurses Association conducts national NP examinations for primary care (family/all ages). The CNO has adopted this examination as the standard for entry-to-practice for Ontario NP-PHCs.

6. Ongoing Competency

51. The CNO's Quality Assurance (QA) program for NPs consists of three elements: reflective practice; practice review; and the CNO's practice-setting consultation initiative. All CNO registrants, including Nurse Practitioners, are required to participate in the Reflective Practice Program. This program involves a five-step process. Each year, nurses are required to: complete a self-assessment of their practice, obtain feedback from a peer of their choice, evaluate the results of the previous year's learning plan, develop a learning plan for the current year, and implement the learning plan.

52. In addition, all NPs are required by the regulations to undergo a practice review at the end of their first three years or first 1800 hours of practice as NPs (whichever occurs first). The practice review can include either an Observed Simulated Clinical Examination or a chart audit.

7. Development of Extended Nursing Class

53. In April 1997 - Bill 127, the *Expanded Nursing Services for Patients Act* received first reading and was proclaimed in 1998. This legislation set out a scope of practice for NPs or members of the "extended class" of nurses and protected the title of Registered Nurse (Extended Class). Nurses in this class were granted the authority to practice within a broader scope of practice which included three additional controlled acts: communicating a diagnosis, prescribing a limited range of drugs, and ordering certain tests, x-rays and ultrasound. However, the use of the name, Nurse Practitioner, was not a protected title until 2008.

54. In May, 1998, the College of Nurses issued its Extended Nursing Class designation which formally set out the Nurse Practitioner scope of practice. This

13 A Report to the Minister of Health and Long-Term Care on the on the Review of the Scope of Practice for Registered Nurses in the Extended Class (Nurse Practitioner), March 2008, submitted by the Health Professions Regulatory Advisory Council. AOM0017415.

includes the general principles of NP practice, the scope of practice and autonomy, health assessment and diagnosis, therapeutic management including dispensing medications, ethical practice and inter professional care and consultation.[14]

55. In 1998 the Minister of Health and Conservative government announced the release of $5 million for PHCNP positions in community based agencies including community health centres, aboriginal health access centres, and nursing stations.

56. As with midwives, the number of Nurse Practitioners have continued to steadily grow. Prior to regulation there were only about 100 Primary Care Nurses. The number today is around 3,000. Currently there are 250 places for new entrants at the university entry level. The educational program has expanded and become even more challenging as the Nurse Practitioner scope of practice has expanded.

8. Expanding Scope of Practice of Nurse Practitioners

57. Controlled acts are health care activities that carry a substantial risk of harm if performed by unqualified personnel. Under the *Nursing Act, 1991*, registered nurses (RNs) can perform three controlled acts when ordered by another health professional that is authorized to perform them. These acts are: performing a procedure on tissue below the dermis or the surface of a mucous membrane, administering a substance by injection or inhalation, or putting an instrument, hand or finger beyond a body orifice or artificial opening in the body. RNs can also initiate procedures involving these acts, that is, perform them without an order, in circumstances permitted by the regulations.

58. In 1998, the *Nursing Act* was amended to allow registered nurses in the extended class (RN-ECs) to perform three additional controlled acts that RNs are not permitted to perform; 1) communicating a diagnosis; 2) ordering the application of a form of energy designated by regulation (the regulation designates diagnostic ultrasound of the abdomen, pelvis and breast); and 3) prescribing a drug designated by regulation.

59. In 1994 when Nurse Practitioners became a registered health profession the list of medications we could prescribe was very short. Since then it has grown steadily. In order to maintain competency continuing study is required for both current and emerging drugs, and their interactions. Currently we can order all of the same pharmaceuticals as a physician except for controlled drugs and

14 College of Nurses of Ontario, Practice Standard, “Registered Nurses in the Extended Class, released May, 1998 and updated to 2004; CNO Practice Standard - Registered Nurses in the Extended Class, (January 1, 2004), AOM0002470. A further revised version was issued in 2011 as the College of Nurses of Ontario, Practice Standard, “Nurse Practitioner”. College of Nurses of Ontario: Practice Standard - Nurse Practitioner Revised 2011, (January 1, 2011), AOM0016128.

substances. The *Nursing Act* also empowers nurse practitioners to independently administer by injection or inhalation a drug they have prescribed.

60. Other legal and regulatory changes were as follows:

(a) The regulations under the *Nursing Act* were amended to authorize NPs to autonomously perform a wider range of procedures than those performed by RNs – for example, suturing a wound.

(b) The *Healing Arts Radiation Protection Act* has also been amended to allow NPs to order x-rays of the chest, ribs, arms, the wrists, hands, legs or ankle and to order mammograms.

(c) The regulations under the *Laboratory and Specimen Collection Centre Licensing Act* were amended to permit nurse practitioners to order specific laboratory tests.

(d) The *Regulated Health Professions Statute Law Amendment Act, 2009* amended 26 health-related statutes, including the *Regulated Health Professions Act, 1991* and *Nursing Act, 1991,* and introduced a number of significant changes for nursing practice. Thus far these changes have expanded the scope of NPs to include:

(i) Admit persons to hospitals and treat in hospital.

(ii) Provide client care orders to be implemented by RNs and RPNs for procedures related to diagnosing and treating clients (e.g., venipuncture to obtain blood samples).

(iii) Broadly prescribe drugs appropriate for client care (i.e., NPs no longer have to prescribe from a list of drugs).(with the exception of controlled drugs and substances).

(iv) Dispense, compound, and sell drugs in keeping with the regulation.

(v) Set or cast a fracture of a bone or dislocation of a joint.

(vi) Order any laboratory test appropriate for client care (i.e., NPs no longer have to order from a list of laboratory tests).

(vii) Order diagnostics and treatments for hospital in-patients and discharge patients from hospital. (This does not change the diagnostic test list, which is still in effect for all NPs in all practice settings.)

(viii) Order services for which patients are insured. (These amendments support the previously noted changes related to ordering laboratory tests and treating hospital patients).

61. The NPAO, CNO and the MOHLTC are continuing to work on the regulatory framework to facilitate the further expansion of scope including:

- removing the restrictions on the diagnostic tests that NPs can order (i.e., eliminate the diagnostic test list);
- permitting NPs to perform point of care laboratory tests;
- permitting NPs to apply specified forms of energy (e.g., defibrillation);
- permitting NPs to order additional forms of energy (e.g., Magnetic Resonance Imaging);
- permitting NPs to order CT scans; and
- permitting NPS to prescribe controlled drugs and substances.

62. I have been advised by MOHLTC that they are looking to enhance the NP scope of practice to include the above current excluded areas by the Fall of 2016. The ability to prescribe controlled drugs and substances will permit NPs to better carry out their practice responsibility, which now authorize NPs to provide medical assistance in dying according to Bill C-14, *An Act to Amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying).* Physicians and NPs are the only health practitioners authorized to provide medical assistance in dying under that legislation.

63. In sum, the NP scope of practice has been expanding constantly, which has worked to close the scope of practice gap between CHC NPs and physicians. NPs now can carry out many of the duties previously performed by family physicians, including communicating a medical diagnosis, providing comprehensive care from “cradle to grave,” providing prenatal and postpartum care and newborn care, and caring for clients with chronic disease. NPs can prescribe drugs (except controlled substances and that is coming), all lab tests, most diagnostic tests (with the exception of MRIs and CT scans, but that is coming too), admit and treat patient in hospitals and perform the same minor surgical procedures as family doctors in a clinic.

64. Many of these duties are controlled acts, previously only within a doctor's scope of practice, but now also within the scope of practice that NPs are authorized to independently undertake. While there are other controlled acts that only physicians are authorized to perform, these are not normally performed by family physicians (conducting the delivery of a baby, fitting or dispensing dentures,

prescribing a hearing aid, prescribing or dispensing eyeglasses or contact lenses and moving joints of the spine).[15]

65. As set out later in this affidavit, at the same time the NP scope of practice has grown to close the scope of practice gap between CHC NPs and physicians, the pay gap has grown.

IV. NURSE PRACTITIONER - PRIMARY HEALTH CARE NP:PHC

66. As set out above, NPs are registered in Ontario with one of three specialties. My focus in this affidavit is on the Nurse Practitioner-Primary Health Care (NP-PHC) specialty. Primary Health Care Nurse Practitioners are specialists in primary health care and provide accessible, comprehensive and effective care to clients of all ages. They provide individuals, families, groups and communities with health services in health promotion, disease and injury prevention, cure, rehabilitation and support. NPs-PHC establish collaborative relationships with physicians and most often work as part of inter professional teams in a variety of health care settings. The NP's knowledge and skills include the ability to:

(a) Provide wellness care such as monitoring infant growth and development and health screening activities such as Pap smears;

(b) Provide counselling and treatments to assist individuals with lifestyle decisions, such as smoking cessation and weight loss;

(c) Diagnose and treat illnesses and health conditions;

(d) Diagnose and treat injuries;

(e) Care for women during and after pregnancy; and

(f) Care for individuals with chronic diseases.

V. COMMUNITY HEALTH CENTRES AND ROLE OF NURSE PRACTITIONERS

1. Community Based and Managed Primary Health Care

67. Community Health Centres were developed in the late 1970's in Ontario, at the same time as midwifery was also re-emerging in Ontario. Community Health Centres introduced a more collaborative form of client health care, although physicians continue to be the top profession in the Centre.

68. Community Health Centres share many of the same core objectives as midwives, although the model of care is different. They take a comprehensive and holistic approach, with a focus on health promotion, preventative care and client-centred

15 College of Nurses of Ontario, RHPA Scope of Practice, Controlled Acts Model (2014) AOM0017418 at p. 6.

care. CHCs also take a collaborative and interdisciplinary approach, where health providers from a variety of disciplines work together and also coordinate with community agencies.

69. Nurse Practitioners have been shown to be highly effective in the care we provide, especially in managing chronic conditions. The unique approach of Nurse Practitioners is ideal for the CHC environment. Rather than a reductionist approach focused only on targeting particular conditions, Nurse Practitioners take a holistic approach, which engages the social determinants of health.

2. Client Care

70. At the East End CHC, where I worked from 2001-2012, all new clients were first assessed by an NP, who then determined which practitioner should take over care. The clients were not rostered to particular practitioners, but instead the CHC served a pool of clients. I provided care to about 600 clients. Many of the clients of the CHC would never see a physician. By the time I left the CHC, I consulted with a physician on about 3% of my clients.

71. Currently, Ontario has 25 Nurse Practitioner-Led Clinics, serving 60,000 Ontarians, with no physicians on staff. At these clinics, the physician only attends the clinic as requested to perform tasks outside of the NP scope of practice, such as prescribing controlled substances.

72. As an NP at the East End CHC, I was able to order the same range of pharmaceuticals as the physicians, with the exception of controlled drugs and substances. However, as set out above, it is expected that NPs will be authorized to order controlled drugs and substances in the near future.

73. At the East End CHC, most clients were booked for a 30-minute appointment. The expectation was that approximately 20 minutes would be used for meeting with the client and 10 minutes for charting. The clients were booked in 30-minute slots, regardless of whether they were seeing a physician or NP.

74. The client population served by CHCs tends to be diverse, complex and often vulnerable. A recent study has found that NPs see a larger proportion of women, younger, and more socially complex clients compared to family physicians.[16]

3. Staffing

75. The respective roles played by CHC physicians, Nurse Practitioners and other professional staff in the Community Health Centre varies by CHC. All of these health professions work in an employment model; that is, all are salaried employees of the CHC, and all positions are funded by the MOHLTC.

16 Benchmarking for Nurse Practitioner Patient Panel Size and Comparative Analysis of Nurse Practitioner Pay Scales: Update of a Scoping Review, March, (2015), AOM0017417.

76. At the East End CHC in 2012, there were four doctors and four NPs. Of the four doctors, two were full-time women, one was a full-time man and the fourth position was split part-time between a man and a woman. Each client was assigned to either an NP or a physician as their primary care provider. Each client also would have a secondary care provider, to provide care if the primary care provider was not available. The secondary care provider also would be either a physician or an NP.

77. The Strategic Review of the CHC Program shows the proportion of individual service events by staff type at CHCs (from 2000-2001), with nurses performing more than physicians.

    (a) Physician 32%

    (b) Nurse 43%

    (c) Social Worker 9%

    (d) Chiropody 4%

    (e) Other 12%[17]

78. A 2005 study finds that in many cases, primary care services are shifting from doctors to nurses, with nurses providing as high quality care and achieving similar health outcomes, though with higher patient satisfaction.[18]

4. Interprofessional Collaboration and Programs

79. CHCs provide services and programs in a wide range of areas. These include medical services (provided by doctors and nurse practitioners), counselling/psychotherapy (provided by counsellors), foot care (provided by chiropodists), physiotherapy (provided by physiotherapists), nutrition (provided by dietitians), and client support (provided by client support workers).

80. The inter professional aspect of the work is crucial to CHCs. Part of the NP's role at a CHC is to make connections with dietitians, therapists, social workers, physicians and others in the health care team.

81. In addition, CHCs offer community health programs to maintain wellness and prevent illness. At the East End CHC, where I last worked, their website shows their current community health programs to include breastfeeding support,

17 A Strategic Review of the Community Health Centre Program, prepared for Community Health and Promotion Branch, Ontario Ministry of Health and Long-Term Care, (May, 2001) AOM0000625 at p. 6-7.

18 "Substitution of doctors by nurses in primary care," Laurent M et al, Cochran Database Syst Rev., 2005 Apr 18;(2): AOM0017377.

diabetes support, yoga, family fitness, back pain and sexual health. When I was at the East End CHC, I co-led the diabetes support program with a dietitian. Other NPs also co-led the back pain and sexual health programs. Physicians were not involved in these programs.

5. Administration and Budget

82. Community Health Centres have a significant administrative infrastructure which frees up physicians and nurse practitioners to carry out their clinical and other responsibilities. For example, the East End CHC has an Executive Director, Clinical Coordinator, Director of Finance, Book Keeper, a Data Management Coordinator, and four Medical Secretaries.

83. CHCs have a global budget from the Local Health Integration Network (LHIN) which is received from the MOHLTC. The only CHC profession that has designated compensation funding is the CHC physician, whose compensation is set by the OMA-MOHLTC agreement. The CHC must pay its physicians the salary which is provided for in the MOHLTC OMA agreement. For example, the Executive Director would not be permitted to hire three Nurse Practitioners instead of a physician.

84. When I was at the East End CHC, I participated in administrative functions, such as being on the hiring committee, for hiring other staff members. There were never any physicians on the hiring committees that I was on. All clinical staff were equally involved in committees such as quality improvement, strategic planning, and data standardization.

6. Policy Development, Data Collection and Research

85. Within CHCs, NPs also play an important leadership role in policy development. As primary care providers, NPs collect evidence regarding outcomes, formulate improved practices and then pass on those lessons to management and other health professionals. We are also expected to be aware of emerging research and to integrate new information in order to maintain best practice.[19]

86. Policy implementation at CHCs is especially complex as a result of the diverse and vulnerable populations they service. NPs need to have both clinical expertise in health as well as expertise in caring for people from a psycho-social perspective. For example, during my time as a CHC NP, it became apparent that a number of South Asian women were experiencing domestic violence but felt unsafe reporting the abuses. In response, the NPs initiated a sewing and cooking group, which created a safer space where connections between individuals and NPs could be made.

---

19 College of Nurses of Ontario Practice Standard: Nurse Practitioner, <http://www.cno.org/globalassets/docs/prac/41038_strdrnec.pdf>, AOM0016128.

87. Within CHCs, NPs contribute to the collection and maintenance of data. There are two essential types of data to be collected in CHCs: clinical and research. For clinical data, most NPs use an electronic health record in the same way as do physicians. It is maintained and updated during client meetings.

88. Data collection by NPs can also manifest in more immediate, informal ways. For example, as an NP, I was able to notice when bed bug infestations were emerging in the housing of our patient population. Although bed bugs are not a disease, they cause significant social and psychological distress and suffering. As a CHC NP, I had a responsibility to identify this pattern and respond by promoting and advocating for the resolution of that infestation.

7. Supervision of Students

89. As an NP in a CHC, I supervised RN and NP students. While the university pays a stipend for this work, I was not allowed to keep it and instead placed it in the CHC revenue. CHC physicians also sometimes supervise medical students. The physicians are permitted to keep their university stipend despite the fact that they are on salary at the CHC.

8. Hours of Work

90. The East End CHC is open Monday- Thursday, 8 a.m. to 8 p.m. and Friday to Saturday, 9:00 a.m. – 5:00 pm. On evenings and weekends, there is usually one doctor and one or two NPs on duty. After 8pm the Centre's telephone answering service directs patients to go to emergency or possibly page a doctor. NPs are not formally on-call but may take back-up calls. NPs also may conduct home visits outside of regular hours.

9. Comparison to Statement of MOHLTC CHC Physician Witnesses

91. I have reviewed the statements of MOHLTC CHC physician witnesses, MaryRose MacDonald, Nicole Nitti, and Susan Woolhouse and observe as follows:

(a) With the exception of actually delivering a baby (which most CHC physicians do not do) and (currently) prescribing controlled drugs and substances, in my experience, the NP scope of practice in a CHC largely overlaps with the physician scope of practice, as described in the witness statements. Indeed, NPs are more likely to have the Echo Chronic Pain certificate than CHC physicians.

(b) There is no difference between the clients seen by physicians and the clients seen by NPs in the CHCs where I have worked (other than clients who require controlled drugs and substances being assigned to physicians). I have spent my career working primarily with marginalized, vulnerable populations. Many of my clients have been of low socio-economic status, or refugees/new immigrants.

VI. MATERNITY AND NEWBORN CARE IN COMMUNITY HEALTH CENTRES

92. Community Health Centres provide maternity care to a wide range of women. The respective roles played by CHC physicians, NPs and other professional staff in maternity care varies by CHC. Generally, it is through a shared physician/nurse model assisted where appropriate by other CHC health professionals and often provided through group programs. In some CHCs, such as Queen West, maternity care is generally only provided by the NP.

93. CHC family physicians with a few exceptions, do not provide intrapartum care and do not have hospital privileges to provide such care. They refer patients with at risk pregnancies to obstetricians and in any event generally refer women to obstetricians at 28 weeks of pregnancy or to midwives or obstetricians at the time pregnancy is confirmed.

94. Generally NPs provide a substantial portion of the prenatal and post-partum care for women and care for newborns. The following steps would represent the standard of care NPs provide in CHCs for routine antenatal care:

    (a) Confirm pregnancy within the first trimester by a urine and/or blood bHCG test and calculate the expected date of delivery (including using ultrasound if necessary); perform first trimester lifestyle screening and physical examinations (checking to make sure that there are no active infections and checking for immune status, checking blood type, hemoglobin level); assess for co-morbidities and pre-existing conditions.

    (b) Conduct Integrated Prenatal Screening (around 12 weeks gestation).

    (c) In the second trimester, conduct prenatal assessment and care with measures of the fundal-symphis pubis height, blood pressure, urine tests, weight, fetal heart rate etc. In the third trimester, these assessments become more frequent.

    (d) Test to screen for gestational diabetes between 24 and 28 weeks gestation as per best practice guidelines. Once this is completed, some NPs transfer the woman to a midwife or obstetrician for further prenatal care and antepartum care.

    (e) Once the baby is born, typically see the mother and baby within a few days of discharge from hospital if an obstetrician had delivered the baby for newborn assessment and post-partum assessment and support; and within a couple of months if a midwife had performed the delivery for ongoing assessment, support and well-baby care.

    (f) Provide breastfeeding support to the mother.

95. However, NPs are required to tailor their care to the unique situation of the client. Given the complexity and vulnerability of CHC clients, often otherwise routine antenatal and postnatal care becomes more complicated.

96. In my experience, the tasks performed by NPs in CHCs with respect to prenatal, post-partum and newborn care are the same as the tasks performed by CHC physicians. There was nothing that the CHC physicians did that I did not do when it came to this care. As set out above, in some clinics, like the Queen West CHC, only NPs perform the maternity care.

VII. PHYSICIAN DOMINANCE AND PRIVILEGES

97. In spite of the importance of the work increasingly taken on by NPs, in my experience, there is generally a hierarchical structure within the health care system with physicians at the top. This has been true to varying degrees in every health care environment I have practised in.

98. Starting with my work as a registered nurse at the Hospital for Sick Children in the early 1980's and moving forward, I have observed a hierarchy of health care professions, with the male dominated physician profession at the top exercising control over the other professions, who are mostly highly female predominant. This has affected the inter-professional dynamics significantly.

99. An illustration of this was at the Hospital for Sick Children, where there was a hierarchy of tables in the cafeteria, starting with the male doctors at the head, followed by female nurses and the rest of the female dominated staff. The surgeons had their own private dining room. Cleaners were last. You sat according to your level. Also when I first started in nursing, as a student, we were expected to stand up when a physician came into the nurses' stations.

100. Historically, nurses were expected to refrain from challenging, or even openly making recommendations to doctors, as described in the landmark article "The Doctor-Nurse Game."[20] This article, which is required reading in every nursing program I have attended, describes the "object" of the "doctor-nurse "game" as follows:

> The nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician.[21]

---

20 Stein, Leonard, Arch Gen Psychiatry. "The Doctor-Nurse Game." 1967; 16(6) 699-703. at p. 699; Response to The Doctor-Nurse Game, Revisited_ New England Journal of Medicine(July 12, 1990) AOM0017389.

21 Stein, Leonard, Arch Gen Psychiatry. 1967; 16(6) 699-703. at p. 699; Response to The Doctor-Nurse Game, Revisited_New England Journal of Medicine(July 12, 1990) AOM0017389.

101. Throughout my career, physicians have told me they were the "captain of the ship," or the "quarterback of the team," stating "the buck stops with me." Many physicians continue to believe erroneously, that they must supervise NPs because they believe themselves to be ultimately responsible for the care the NP provides.

102. While physician-nurse dynamics have evolved since the term the "doctor-nurse game" was first coined, the underlying relationships described in that article are still considered highly relevant in the nursing profession.

103. In addition, the medical model I have observed over my years in the health care system since the 1980's was established by physicians and the Ontario government at a time when physicians were highly male dominated.

104. At the time I started practising nursing in 1981, Ontario physicians were 86.2% men.[22] When I started to work in a Community Health Centre in 1986, family physicians in Ontario were 78.1% men.[23]

105. The physicians in the CHCs where I worked during the period of the 1980's and 1990's were primarily male. For example, at both York Community Services and the Lawrence Heights Community Health Centre, most of the CHC physicians were men.[24] Of the clinical staff, physicians in CHCs are at the top of the professional hierarchy.

106. I did not observe until the mid-late 1990's that women started to enter into the positions to a much greater degree. By the early 2000s a significant number of CHC physicians were women. When I joined East End Community Health Services, there was more gender balance in the physicians' positions.

107. While more women have entered into CHC physician positions, in my experience, there is a hierarchy within medicine, with CHC physicians considered to be at the low end of the hierarchy (and specialists at the top).

108. Some health professionals see the CHC model of practice as "lazy" because CHC physicians receive a salary, no matter how many people they see. I have had health professionals tell me that working at a CHC is a "cushy" job. A blog post by Kevin MD, entitled "Salaried physicians are lazy doctors" reads: "Show me a salaried doctor (without a productivity bonus) and I'll show you one who believes strongly in his right to get home by 5pm, regardless of medical problems

---

22 CIHI- physicians, by specialty and gender, and percentage distribution, by gender, Canada, 1978-2014 AOM0017382.

23 CIHI- physicians, by specialty and gender, and percentage distribution, by gender, Canada, 1978-2014 AOM0017382.

24 At York Community Services, the physicians were Russ Springate, Tom McGown, John McFadden and Fay Weisberg; at Lawrence Heights Community Health Centre, the physicians were Wendell Block, Jamie Uhrig and Donna Grogan.

coming through the door, or over the phone, that day."[25] This post reflects the attitudes I have often encountered towards CHC physicians. pay equity for Nurse Practitioners

109. While NPs increasingly have taken on providing health care which is or was performed by physicians, their services are not remunerated in a similar manner. In fact, the more I have observed NPs taking on an increased scope of practice, the more the pay gap between NPs and physicians has increased.

110. Before 1986 I worked at the Hospital for Sick Children where I was involved with pay equity advocacy. During that time pay equity legislation didn't exist so we had to advocate for ourselves. At that time I was working as a Registered Nurse and recall that the Hospital representatives thought that the elevator operators would be an appropriate male comparator to nurses.

VIII. COMPENSATION OF CHC NURSE PRACTITIONERS

1. The MOHLTC Approved Salary Schedule

111. The pay of Nurse Practitioners in Community Health Centres was set by the MOH in its approved Salary Schedule which was initially set when CHCs were established in the late 1970's.

112. As detailed above, when NPs were reintroduced in the early 1990s,the Ministry committed to paying NPs "at a level commensurate with their education and responsibilities" and cited a salary range of $60,000 to $80,000.[26]

113. I was hired effective October 10, 1989 as a Community Health Nurse by Sue Davey, then Executive Director of the Lawrence Heights Community Health Centre. The senior nurse's salary was $37,114 for a minimum 35 hour work week. By 1990 it was $38, 784. At this time nurses were paid on a salary grid.

114. The 1994 MOHLTC Salary Schedule provided for the Nurse I and Nurse II Salary as follows:[27]

Nurse I:	$33,000 - $52,000
Nurse II:	$42,000 - $56,000

25 "Salaried physicians are lazy doctors," KevinMD.com, (July 30, 2007) AOM0017370.

26 Nurse Practitioners in Ontario: A Plan for Their Education and Employment, Ministry of Health, December 1994, AOM0017395 at p. 10.

27 Community Health Centre Program - Approved Salary Ranges from "Developing a New Community Health Centre - Phase II: Needs Assessment and Proposal Development 1994-1996 Guidelines (1994) AOM0002051; MOH Community Health Centre Program Approved Salary Ranges 1994-1996 and portion of report from Hay Group CHC Report re salary and benefits, AOM0001287.

115. The CHC Physician rate was set in that Schedule as $80,000 - $177,766, with a $5,353 on-call allowance. The top rate of the Nurse II position was 70% of the lowest rate for the CHC physician.

116. Salary schedules continued until approximately 2004 or 2005, when the Local Health Integration Networks were created. CHCs then received envelope funding, so were given more discretion regarding how non-physician staff would be paid.

2. 1999 Nurse Practitioner Salary Increase

117. In 1999, I attended an announcement by the Minister of Health, Elizabeth Witmer regarding new government funding for Nurse Practitioner salaries, which set the salary at $57,000 to $70,000 with 20% for benefits. This salary funding was provided by the MOHLTC to Ontario's Community Health Centres for their Nurse Practitioners who were entitled to pay equity under the *Pay Equity Act*.

3. 1999 CHC Hay Report Compensation Review

118. In June 1999 the Hay Group produced a report on CHCs that was commissioned by the Association of Ontario Health Centres and paid for by the MOHLTC. **.** CHC salaries had been frozen since 1994, apart from the pay equity adjustments, which had been funded by the MOHLTC. [28]

119. As part of the report the Hay Group reviewed job documentation from various CHCs in order to identify jobs common to CHCs. The Hay Group then assessed the value of those common jobs, proposed 9 job bandings based on those rankings and used the bands to propose a salary range structure.

120. The Report concluded that the pay levels for CHC physicians were competitive with the market. At that time the Hay Group found that they were unable to provide data for the Nurse Practitioner as a benchmark. The Hay Group also noted that a salary range of $57,000 to $70,000 had already been established by the MOH for the RN (EC) position.[29]

121. The Hay Group found that the 1994 Salary scales prior to pay equity were under market for all positions (other than administrative support jobs) and they recommended increases. The report also recommended that pay equity be

28 Hay Group Association of Ontario Health Centres Salary and Benefit Review Report (June 1, 1999) AOM0005885.

29 Hay Group Association of Ontario Health Centres Salary and Benefit Review Report (June 1, 1999) AOM0005885, at p. 29.

maintained by continuing to provide proxy pay equity adjustments at a minimum of one percent of payroll annually.[30]

4. Increased Salary in Response to June 1999 Hay Report

122. I started work on a contract basis with the East End Community Health Centre on May 1, 2001 as a Nurse Practitioner at the pay rate of $35.89 per hour at level 7. My regular work week was 37.5 hours per week. I was required to work "evenings and weekends and provide on call services".[31]

123. In a memo to me dated December 18, 2003 from Joyce Kalsen of East End CHC,[32] I was advised as follows:

(a) "The Ministry of Health has revised the salary scales for Community Health Centres. To determine these new scales, they hired the Hay Group consulting firm who compared CHC jobs to similar positions in the wider health care job market. The Hay Group found that the 1994 Ministry salary scales (prior to pay equity) were under-market for all positions, and they recommended increases".

(b) "Using the Ministry's new salary scale, and incorporating it into our pay equity plan we have developed a new salary scale for East End CHC which replaces the 7 step increases with 5 steps. This scale is effective as of April 1, 2003. Because our pay equity process raised salaries for most positions above the Ministry's 1994 salary scale, some positions at the East End CHC have compensation rates above the Centre's new salary scale. Staff in these positions will not have their pay reduced but will continue to be paid at their current rate".

(c) "Your position will be affected as follows – Nurse Practitioner

Step Level 5 from Step Level 7

Full time annual salary - change from $69,985.50 to $75,991.50

Retroactive pay to April 1, 2003."

124. In a memo to me dated October 28, 2004 from Joyce Kalsen, I was advised that the "Ministry of Health has recently revised the salary scales for Community Health Centres. The new salaries were based on a consultants' report done for

30 Hay Group Association of Ontario Health Centres Salary and Benefit Review Report (June 1, 1999) AOM0005885 at p. 4-5.

31 Letter dated March 30, 2001 from Joyce Kalsen, Executive Director, East End CHC to Theresa Agnew re: hiring, AOM0017392.

32 Memo to Theresa Agnew dated December 18, 2003 from Joyce Kalsen of East End CHC, AOM0017393.

the Ministry by the Hay Group and bring CHC salaries more in line with similar jobs in the wider healthcare market. We have received funding in our 2004/05 budget to make salary adjustments back to April 1, 2004 for all positions that received an increase."[33]

125. The memo further stated:

"Using the Ministry's new salary scale and incorporating it into our pay equity plan, we have developed a new salary scale for East End CHC which is effective as of April 1, 2004. Your Nurse Practitioner position will be affected as follows:

Step Level 5

Full time annual salary - change from $75,991.50 to $79,989.00

Annual Salary – Your FTE – 0 .85 - $64,592.88 to $67,990.65

Retroactive pay to April 1, 2004.

126. I recall that, in 2004, Minister Smitherman told the Family Health Team Action Group (of which I was a part) that part of the Ministry's job was to attract physicians into the family health teams. He said that the best way to attract physicians into new models of care was "carrots, not sticks". Unfortunately, the Ministry has not applied the philosophy of incentivizing work when it comes to NPs.

5. 2006 Salary increase

127. I recall attending an announcement by Minister Smitherman in 2005 related to increased funding for Community Health Centres and more satellite CHCs. Sue Davey was present. I recall Minister Smitherman saying the Ministry had done work on harmonizing salaries and that additional funding would be provided for staffing.

128. In the time period starting in approximately 2005, the Ministry had two sets of salary guidelines: one for Family Health Teams (which first opened in 2005) and one for Nurse Practitioner Led Clinics (which first opened in 2007). For both of these models, the Ministry had a very prescriptive compensation grid for all staff, other than physicians.[34]

129. In June, 2007, the Ministry increased the approved salary range for Nurse Practitioners with one year of retroactive pay back to April 1, 2006. An NP salary

33 Memo to Theresa Agnew dated October 28, 20104 from Joyce Kalsen, East End Community Health Centre AOM0017394.

34 See, for example: <https://www.rtso.ca/wp-content/uploads/2015/06/MOHLTC-fht_inter_provider-Oct-2013.pdf> (this is updated as of 2013)

in the community was funded at a maximum of $89,203. However, since 2006, salaries of NPs in the CHC's have been frozen at that number[35].

130. While I have watched my and other NPs in CHCs have our compensation frozen or adjusted only in small measure relative to our contributions, I observed the MOHLTC provide CHC physicians with substantial compensation increases.

6. 2009 Hay Report

131. The Hay Group completed a study in 2009 for the Association of Ontario Health Centres "Developing a Provincial Compensation Structure. It found that salary rates for inter professional primary care were 5-30% below market. It was a market based compensation salary review. The study stated that lack of access to the HOOPP pension plan made it even harder to compete with other health care providers that did offer it. The Hay Group using benchmark profiles placed NPs in the same bands as clinical psychologists and advised that NPs should receive an average salary of $92,900 (up from a range of $74,038 to $89,203). CHC Physicians were not included in the analysis. This report was provided to the MOHLTC but not acted upon.

7. Compensation Restraints

132. The MOHLTC has applied its compensation restraint legislation and policies so that NP and other non-physician compensation in CHCs has been frozen for many years at $89,203 (maximum).

8. 2011 Hay Group Report to NPAO

133. The NPAO retained the Hay Group in 2010 to do a report on Nurse Practitioner Compensation to recommend an appropriate level of compensation for Nurse Practitioners.

134. The January, 2011 report, using the Hay job evaluation methodology put NPs at approximately 70% of the CHC physician, even though the actual CHC NP salaries at the time were 46% (not designated underserviced) to 38% (designated underserviced) of CHC physician salaries. The report proposed an increase to NP compensation to a salary range maximum of $135,000 (an increase of approximately 50%). In spite of the report's recognition that NPs should receive a significant compensation increase, I rejected its conclusion that NPs and Physician Assistants should be closely grouped. Physician Assistants were not a regulated profession and their scope of practice is entirely delegated

35 "Low wages and benefits makes interprofessional primary care a hard sell", Nurse Practitioner Association of Ontario, http://npao.org/2014/09/low-wages-benefits-lower-appeal-primary-care-work/, Accessed September 11, 2015, AOM0017376.

and supervised, without the autonomous authority to perform any controlled acts.[36]

9. 2012 Hay Group Report – "Developing a Provincial Compensation Structure for Primary Care Organizations"

135. In 2012, the Primary Care Compensation Working Group (PCCWG) commissioned a further compensation report for the development of a common primary care compensation structure for the following inter professional primary care models in Ontario: Family Health Teams (FHTs), Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs) and Nurse Practitioner Led Clinics (NPLCs). The PCCWG is composed of representatives from the Association of Ontario Health Centres (AOHC), the Association of Family Health Teams (AFHTO) and the Nurse Practitioners Association of Ontario (NPAO).

136. The Hay Group's 2012 Report again found that the Nurse Practitioner and Psychologist should fall together in Band 10. The Hay Group determined that these positions should be considered as "market exceptions", i.e. the value placed on these positions by the market is not directly related to the internal value as determined through job evaluation. Therefore the salary ranges for their positions should be established solely based on market considerations.[37] The resulting recommended "Market Exceptions" salary range was $103, 322 - $135, 916 (over six steps). Although this report again recommended a significant increase from the MOHLTC salaries for NPs (an increase at the low end of the range of 40% and at the high end of 52%), I questioned whether the Hay Group had evaluated NPs appropriately. Positioning the NP together with the psychologist was based on the conclusions in the Hay Group's 2009 report and did not take into account NPs' expanded scope of practice from the 2009 legislative changes.

137. I have found it frustrating that physicians are typically excluded from compensation reviews. These reports rarely suggest that the physician salary should be scrutinized.Hay decided in this Report to exclude the CHC family physician from this analysis as such physician compensation was determined separately by the MOHLTC through an agreement with the OMA. The NPAO wanted the physician to be part of the analysis. It is a reflection of the medical dominance of the MOHLTC compensation system that the MOHLTC sanctions giving preferential and distinct status to physicians in the CHCs.

138. In providing its recommendations, the Hay Group also recognized the importance of compliance with pay equity. The 2012 Report noted that "Every

---

36 Hay Group Health Care Consulting Final Report to Nurse Practitioners Association of Ontario (NPAO) Compensation Consulting Services (January, 2011) AOM0007558.

37 "Developing a Provincial Compensation Structure for Primary Care Organizations" submitted to: AOHC, AFHTO and NPAO (2013), AOM0001003 at page 25.

public sector employer in Ontario must have a pay equity plan that meets the requirements of the Pay Equity Act. The purpose of pay equity is to ensure that there is equal pay for jobs of equal value (as determined through a gender neutral job evaluation plan), thereby ensuring that "female" job classes are paid on an equivalent basis to male jobs of equal value." [38]

139. The Hay Group provided the primary care organizations with guidelines for implementing pay equity.[39]

140. The Hay Group however, carried out a compensation and salary structure review and did not conduct an analysis under the *Pay Equity Act and did not analyze what adjustments might be required under that Act.* . This is a separate process which has yet to be analyzed at this time.

141. The RNAOs Submission to the Provincial Gender Wage Gap Review Committee highlights the gender pay inequities faced by Nurse Practitioners and registered nurses as highly female dominated health professionals. [40]

10. 2013 AFHTO, NPAO and AOHC Report to MOHLTC

142. Based on the above-noted 2012 Hay Group report, the AFHTO, NPAO and AOHC prepared a June, 2013 report to the MOHLTC, "Toward a Primary Care Recruitment and Retention Strategy for Ontario". [41]

143. The report noted that there was a recruitment and retention problem, with the highest vacancy rates for Nurse Practitioners, at 19%. The key issues were identified as "compensation levels below market, the compensation gap is growing and lack of pensions is a barrier to labour mobility." [42]

144. The 2013 report noted that the average NP works for 16 years as a Registered Nurse before obtaining NP qualifications and found as follows:

(a) The minimum salary for a Primary Health Care Nurse Practitioner (PHC NP) in NPLCs, CHCs and AHACs was the lowest starting salary for an NP in Canada with the exception of one other jurisdiction. Moreover, an ONA nurse with 8 or more years of experience would make more than the

38 "Developing a Provincial Compensation Structure for Primary Care Organizations" submitted to: AOHC, AFHTO and NPAO (2013), AOM0001003, at page 32.

39 "Developing a Provincial Compensation Structure for Primary Care Organizations" submitted to: AOHC, AFHTO and NPAO (2013), AOM0001003, at page 32.

40 Registered Nurses Association of Ontario Submission to the Gender Wage Gap Strategy Steering Committee (January 16, 2016) AOM0017426.

41 AFHTO, NPAO and AOHC June, 2013 Report to the MOHLTC, "Toward a Primary Care Recruitment and Retention Strategy for Ontario" (June 2013) AOM0001007.

42 AFHTO, NPAO and AOHC June, 2013 Report to the MOHLTC, "Toward a Primary Care Recruitment and Retention Strategy for Ontario" (June 2013) AOM0001007, P.2.

maximum salary for a PHC-NP. Also, all other jurisdictions in Canada exceeded Ontario's maximum rate for NPs. [43]

(b) The report emphasized that, in the last few years, the role of NP had changed dramatically in Ontario. Despite the changes, no commensurate change had occurred to the salary of NPs working in the community. In fact, NPs had experienced a wage freeze for the past six years. [44]

(c) CCACs across Ontario had begun recruiting PHC NPs into community-based palliative care teams, with positions posted at $115,000 per annum.[45]

(d) The hospital sector had been able to recruit and retain experienced NPs with salary levels averaging $103,000-$108,000. Because the community sector could not compete, the vacancy rate for NP positions was 19% in CHCs, FHTs, AHACs and NPLCs." [46]

(e) Historically, the Hay Group had evaluated NP positions at the same band level as Clinical Psychologists. The salary range for a Clinical Psychologist as set by the MOHLTC ($103,300 to $135,900) corresponded to the same salary level which the Hay Group recommended for NP's in its 2011 report to NPAO. This now set the stage for a potential pay equity challenge. [47]

145. Our NPAO Board would still like to see Nurse Practitioners in the CHCs compared to family physicians. This is in fact is what Mr. Durber did in his report in this proceeding. I was very heartened to read the Durber report as it is the first time I have read an evidenced based comparison analysis of the work of Nurse Practitioners with Family Physicians.

IX. 2016 ANNOUNCEMENT

146. In the 2016-2017 provincial budget, the government has made a commitment to increase funding for compensation in CHC, FHT, NPLC and AHAC organizations but it is not clear what these increases will mean for Nurse Practitioners. The

43 AFHTO, NPAO and AOHC June, 2013 Report to the MOHLTC, "Toward a Primary Care Recruitment and Retention Strategy for Ontario" (June 2013) AOM0001007, P.3-4.

44 AFHTO, NPAO and AOHC June, 2013 Report to the MOHLTC, "Toward a Primary Care Recruitment and Retention Strategy for Ontario" (June 2013) AOM0001007, P.4.

45 AFHTO, NPAO and AOHC June, 2013 Report to the MOHLTC, "Toward a Primary Care Recruitment and Retention Strategy for Ontario" (June 2013) AOM0001007, P.4.

46 AFHTO, NPAO and AOHC June, 2013 Report to the MOHLTC, "Toward a Primary Care Recruitment and Retention Strategy for Ontario" (June 2013) AOM0001007, P.4.

47 AFHTO, NPAO and AOHC June, 2013 Report to the MOHLTC, "Toward a Primary Care Recruitment and Retention Strategy for Ontario" (June 2013) AOM0001007, P.4.

commitment is for an additional $85 million over three years for non-physician employees of those organizations. This funding has not yet been implemented.

147. The salary guidelines with the grief for NPLCs and FHTs was taken off the MOHLTC website around 2014 for reasons not know to me as this grid was still being applied.

X. CHC PHYSICIAN COMPENSATION

1. Introduction

148. The CHC Physicians' compensation was frozen up to 2003. At that time, the CHC physicians worked to get a committee of the OMA established to address the interests of primary care physicians. As a result of that intervention, the OMA negotiated provisions to align the compensation of CHC physicians with other primary care providers.

149. At that time, the compensation for CHC physicians changed to a base salary plus a series of incentive payments and bonuses. In 2010 it returned to an increased base salary.

150. During the period since the reintroduction of NPs in the early 1990s, the OMA has achieved six agreements with the MOHTLC, each of which resulted in an increase in compensation, with the exception of the 2012-2014 contract, which included a small short-term decrease and 2015 unilateral imposition of non-agreed OHIP fee codes by the MOHLTC.

2. MOHLTC's Alignment of CHC Physicians Compensation with Other Primary Care Physicians under OMA Agreements - 2003 – 2009

151. While earlier agreements between the MOHLTC and the OMA focused on fee codes rather than salaried compensation for CHC physicians, in 2004, CHC physicians lobbied within the OMA to obtain a separate internal committee that could more effectively advance their interests within the OMA structure and to the MOHLTC for compensation increases. This committee, the Primary and Community Care Committee of the Physicians Services Committee was later agreed to in the 2004 OMA MOHLTC agreement.

152. This committee was successful in obtaining a very substantial increase in CHC physician compensation in the OMA agreement with the MOHLTC effective 2004-2008.[48] This increase in compensation included moving to a salary plus incentives model. As well, physicians with more than five years of experience received an additional $5,000 service recognition payment. Those with more than 30 years of experience received an additional $10,000 payment. As well, as

48 Agreement between OMA and MOHLTC, April 1, 2004 – March 31, 2008. AOM0000634.

a result of the OMA agreement, the funding for CHC physicians' compensation could not be used for other purposes in the CHC.

153. By letter dated November 3, 2005, MOHLTC Minister Smitherman wrote to the Community Health Centres to advise that the new funding would address the salary ranges required to ensure that CHC physicians are funded equitably in terms of the 2003 OMA Re-Opener Agreement and provided as additional 2.41% base adjustments as per the 2004-2005 OMA agreement. These changes resulted in the following new salary scales retroactive to April 1, 2004 (in addition to the on-call payments).

Non-underserviced communities - $113,265 to $136,455 plus a one-time $4660 in salary linked adjustment payments;

Northern/underserviced communities - $143,580 to $172, 975 plus a one-time $4660 in salary linked adjustment payments

154. This increased compensation was designed to "harmonize compensation for Community Health Centre (CHC) physicians with that of physicians in other aligned models of primary health care. Community Health Centres are an important part of the Primary Health Care Renewal Strategy. I believe it is essential that the physicians employed in the CHCs are compensated equitably for the important work that they do as part of the provider team" [49]

155. The CHC physicians were also now entitled to 25% in benefits and relief.

156. As well, the above OMA agreements provided that the CHC physicians also received increases in the following years as follows:

(a) July 1, 2006 – 0.11%

(b) October 1, 2006, 1.16%

(c) January 1, 2007 - .67%

157. In May, 2007, the Primary and Community Care Committee (PCCC) approved interim and retroactive incentive payments in addition to the above salary increases, to be paid to CHC physicians in accordance with the incentive payments provided for in the OMA agreement which were implemented by the MOHLTC. These incentives included:

Interim Payments (April 2007 to March 2008):

- Interim payment for Comprehensive Care Management (CCIvI) based on achievement of 60% of enrollable clients

49 Letter from George Smitherman, Minisiter, MOHLTC, to East End CHC re compensation of CHC physicians (2005-11-03) AOM0013458.

- Additional payment of $7000/FTE related to projected pooled value of incentive and bonus claims
- The interim payments in 2007-2008 replace the $4660 paid in previous years.

Projected Value: $17,936/FTE

Retroactive Payments (October 2005 to March 2007):

- Interim payment for Comprehensive Care Management (CCM) based on achievement of 60% of enrollable clients
- Additional payment of $2340/FTE related to projected pooled value of incentive and bonus claims (differential between $7000 and previous payment of $4660/FTE)

Projected Value: $20,664/FTE.

158. In September, 2008, the OMA informed its members that the MOHLTC came to an agreement with the OMA, which provided for substantial increases in compensation for physicians including CHC physicians.

159. During the period 2006 to 2008, the CHC physician compensation increased from $150,499 to $155,399. This new OMA agreement took them from $155,399 in 2009 to $217,687 in 2011, a 40% increase in salary. It provided that effective April 1, 2009, Community Health Centre (CHC) physicians will receive "monthly incentives and bonus payments" including a "three percent General Fee Payment (3% GFP) applies to these eligible incentives and bonuses per the 2008 Physician Services Agreement negotiated between the Ontario Medical Association and the Ministry".[50] The deal was completed in September 2008 in the midst of the financial crisis and ratified by OMA members in early October 2008.

3. Bonuses and Incentive Payments to CHC Physicians

160. From 2004 to 2010, as a result of the work of the OMA, CHC physicians were eligible for Salary Linked Adjustments (SLA) and Comprehensive Care Management Fees (CCM). SLAs refer to the amount paid in lieu of incentives and bonuses given to fee for service primary care physicians. For most of my career these were not available in CHCs but they became available to CHC physicians after the OMA negotiated specifically on behalf of CHC physicians. Examples of incentive payments include the after-hours premium, new and unattached patient fees, chronic disease management fees, special payments (e.g. serious mental illness), and preventative care management fees.

50 Ministry of Health and Long-Term Care, "Community Health Centre (CHC) Payment and Reporting Guide", Fact sheet from MOH re CHC payment and reporting guide (April 1, 2009) AOM0000626.

161. During this period in the CHC model, the CCM fee per physician depended on the average number of enrolled patients for all physicians (all patients enrolled by CHC physicians were pooled). However, for a majority of the relevant period the MOHLTC did not have access to actual data and relied on estimates in order to make CCM and SLA payments.

162. The MOHLTC made interim and retroactive payments to all CHC physicians during this period in amounts based on an estimate of the actual earnings that were supposed to be verified once information systems work had been completed. These funds were protected, to be used only for funding physician salary. CHCs were asked to return surplus not spent on physician funding. They could not be used for any salary adjustments for other other CHC staff.

163. In order to be able to verify these estimates and begin paying bonuses based on actual service, CHCs were asked to roster patients to CHC physicians and to collect information regarding service provision. NPs took on the majority of the work of rostering all CHC patients to physicians. In 2008 or 2009, I recall attending a clinical meeting at the East End CHC and being told that we were required to record certain data differently. The organization required us to do this so that the physicians could be paid certain bonuses and incentives, even though they were being paid for the work we were doing. Many of these patients had never seen a physician. NPs were asked to create a record showing their patients were in fact patients of the physicians. As the primary care provider, I felt that this mandate to roster my patients to physician partners undermined my authority,autonomy and dignity.

164. The incentive system resulted in physicians receiving payment for work which they did not carry out, but rather was done by NPs, registered nurses and other health care professionals performed in the CHC. For example, after the OMA contract, if I did a pap smear or cessation of smoking counselling, I would "shadow bill" under the CHC doctor, who would receive the incentive bonus for that work even though they performed no work and it was not their patient. Although I believed in inter professional collaboration and teamwork, it did not feel like a proper team when what it meant was that I was contributing my work to the physician's compensation. In addition, this was occurring while NP compensation had been frozen.

165. Our CHC physician colleagues ultimately agreed that it was not fair for them to be paid for NP work. These incentives were subsequently taken out of the OMA agreement for CHC physicians around 2010.

4. On Call Work and Payment

166. Mostly, doctors provide any on call work they do by phone. Community Health Centres are required by the MOHLTC to have on call coverage. Only physicians are compensated for the work. Occasionally, where no doctor is available, an

NP would be allowed to be on call, but she would never be compensated for it. Barriers faced by Nurse Practitioners

5. Introduction

167. The NPAO has frequently made submissions to the MOHLTC about the barriers faced by NPs and the need to more effectively leverage the skills and contributions of NPs to create a healthy Ontario. See, for example, the NPAO 2014 Report, "Better Care. Better Value, A Plan from the Province's Nurse Practitioners for a Healthy Ontario."[51]

168. In addition, over my career, I have worked to help remove the unnecessary barriers to the scope of practice of Nurse Practitioners.

169. A significant part of this work is navigating the complex policy relationship between the male dominated OMA and other predominantly female health care professional organizations and the MOHLTC.

170. In my interactions with the Ontario Medical Association since 2001, I have found the organization's decision-making structure to be male dominated. The composition of the OMA Board and Executive and Chair of OMA council up to 1992 were 100% male. Over 20 years later, there has not been a major change in the male predominance of its leadership, despite the increasing numbers of female physicians: In 2013, 5 out of 6 members of the Executive were men, (approx. 83%) and 17 out of 19 members of the Board of Directors (89.5%) were men.[52]

6. Unequal Bargaining Systems

171. In my experience, the MOHLTC treats bargaining with the OMA very differently than with any other organization, including the NPAO. For example, the OMA is often given a "seat at the table" for negotiations concerning nurses. However, the nursing organizations are not given a seat at the table for negotiations affecting doctors.

172. Even where negotiations with the OMA addressed NPs, we were not represented in the negotiations and were not entitled to send a representative. Meanwhile, during NPAO efforts in 2004 to negotiate a province wide template agreement for NPs, the MOHTLC insisted that OMA be at the table. We were close to finalizing a template, but the discussions went off the rails. When we tried to go back to the Ministry, they refused to talk about it.

---

51 NPAO Report, "Better Care. Better Value, A Plan from the Province's Nurse Practitioners for a Healthy Ontario', (March 20, 2014) https://npao.org/pdf/NPAO_Better_Care-Better_Value_Web.pdf AOM0017424.

52 See Chart OMA Leadership Gender Breakdown with a sampling of years and the names and sexes of the members. Source: Issues of the Ontario Medical Review.

173. When I became Executive Director of the NPAO in 2012, I took the template agreements into my first meeting with MOHLTC ADM Susan Fitzpatrick. She swept the table and put them on the floor and said "we're a funder, we don't negotiate contracts." Since then, at different times, we have tried to go back but have been unable to open up the conversation with the MOHLTC.

174. Often broad health care policies are developed between the OMA and the MOHLTC at their negotiations. Such decisions frequently result in limitations being imposed on other health professionals. Examples of this include the incentive system for physicians, described above, which resulted in NPs attributing our work to physicians, as well as the consultation fees for physician and not NP referrals, as described below.

7. Fee Based Physician Compensation and Medical Dominance

175. I have often observed the negative impact of incentive based programs aimed at physicians. For example, within CHCs, for a period, physicians were receiving an on-call incentive which meant that an NP could not also provide on-call services.

176. I understand from reviewing the materials that midwives have observed physicians forcing medically unnecessary transfers of care, which results in the province paying twice. In the NP profession we have similar issues rooted in medical dominance and fee code based care.

177. This issue can also be illustrated by the difficulties NPs encountered until recently when making specialist referrals. It is within the scope of practice of an NP to refer a patient to a specialist when required, based on the findings of a comprehensive assessment. Without a request from a physician, the specialist can only claim the medically specific assessment fee, not the consultation fee. Consequently, the remuneration to the specialist is approximately 25% lower than the comparable fees resulting from a physician referral. To circumvent this problem, many specialists' offices until recently required the signature of a physician on an NP-initiated referral. This often resulted in the consultation note being sent to a family physician who has never seen the patient, and creates serious medical-legal concerns, as well increased costs to the MOHLTC resulting from duplication of service, and delayed follow-up on the plan of care. It also seriously undermines the scope of practice of NPs and the collaborative spirit which is required for interdisciplinary teams to provide effective patient care.

178. Generally I feel that the way fee for service issues have come to dominate how care is provided is an excellent illustration of the physician/OMA domination within the health care realm. To give another example, I am aware that allowing doctors to bill for service in the CHC setting is also starting to push NPs out of primary care clinics. This is a way for clinics to save money in their global funding budget. I know of four Ontario public health units (which use global funding) who have fired salaried nurse practitioners and hired doctors who bill fee for service. Doing this takes the patient care cost pressures off of the budget.

XI. INTERVIEW WITH PAUL DURBER

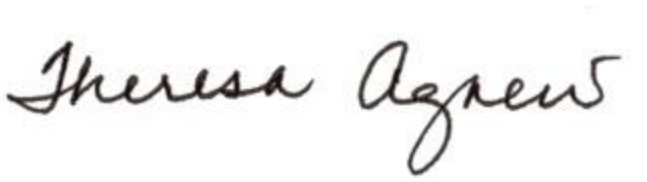
179. I was interviewed by Paul Durber on September 20 2013. During this interview we discussed a wide range of topics including how the scope of practice for Primary Care Nurse/ Nurse Practitioner has change over the years, types of services we provide (for example, home visits, research, administrative work).

180. I also described my perception of the role of gender within the Ontario Health Care system. I noted that "there are still some gender barriers .. given that the system remains fairly physician centered."[53]

181. The analysis of the Nurse Practitioner position in the CHC done by Durber is far more detailed and substantive than I have ever seen before. Mr. Durber asked probing questions and it was clear to me that he wanted an honest and comprehensive view of the NP role. He ultimately situated the NP within the broader healthcare system in a manner that reflected a fair and comprehensive understanding of our profession's role.

SWORN this ► day of July 2016.

A Commissioner for taking Affidavits



Theresa Agnew

53 Notes of Paul Durber: "Interview with Theresa Agnew – Primary Care Nurse (20 September 2013) AOM0000870.