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 MOSHE GREENGARTEN

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

1. I was the Associate Director of Hay Health Care Consulting ("Hay Group") and the lead consultant responsible for the development of the 2003, 2004 and 2008 Hay Reports which were prepared for the Association of Ontario Midwives and referred to by the parties and experts in this proceeding. I was also the lead consultant responsible for the creation of compensation reports relating to the staff in Ontario's Community Health Centres and in relation to the compensation for Nurse Practitioners in Ontario.

2. My background, knowledge and experience which supports the statements in this affidavit are set out in my Curriculum Vitae[1] and summarized in Part I below. This affidavit constitutes the main section of my examination in chief in this proceeding.

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1 Curriculum Vitae of Moshe Greengarten AOM0016610.

I. BACKGROUND

1. Education and Training

3. I studied at the Hebrew University of Jerusalem and the University of Toronto, receiving B.A., M.A. and Ph.D. degrees in Political Science. I also received a M.B.A. from the University of Toronto**.**

2. Health Care Executive Experience

4. From 1978 to 1998, I was a senior health care executive at Baycrest Health Sciences Centre.

3. Professional Consulting Experience

5. I have served as an executive and consultant in health care for over 30 years. I am now retired but continue to provide advice from time to time to the now merged Korn Ferry Hay Group.

6. In my role with the Hay Group, I had responsibility for consulting services focusing on health human resources and organizational development across Canada.

7. Over the course of my consulting career, I have conducted over 500 consulting assignments. My clients include a broad range of health care organizations. I provide professional consultation services including facilitation, governance reviews, leadership development, strategic planning, executive assessment, compensation and executive compensation reviews. Much of my practice involves consulting to chief executives, boards of directors, senior managers and professional leaders of hospitals and health care organizations across Canada.

8. As well, I have substantial consulting experience as set out in this affidavit with compensation reviews with respect to Community Health Centre staff, Association of Aboriginal Health Centres and Family Health Teams and with midwifery compensation reviews.

9. Prior to my retirement, I was a certified member of the Canadian College of Health Leaders (CHE).

4. Academic Roles

I am an Adjunct Professor in the Institute of Health Policy, Management and Evaluation of the University of Toronto from 1990 to the present.

II. JUNE 2003 AOM COMPENSATON REVIEW REPORT

1. Response to AOM Request for Proposal

10. In January, 2003, I responded on behalf of the Hay Group to the AOM's January 2003 Request for Proposal for a Salary and Benefit Review of Midwives in Ontario. [2] The RFP set out the goals of the review as follows:

(a) Identifies appropriate comparators for compensation for Ontario midwives;

(b) Reviews the midwifery fee, the operations fee and the benefits fee provided to midwives for each billable course of care they complete;

(c) Develops recommendations for AOM as to what level of compensation would be fair for midwives (in all 3 categories listed in b) in Ontario 10 years after the establishment of the current compensation schedule;

(d) Recommends a compensation scale that would be appropriate including a mechanism for how Ontario midwives migrate up the scale over time;

2 AOM Request for Proposals Compensation Review Project (2003-01-27) AOM0005884.

(e) Recommends the % amount of the midwifery fee that would be most appropriate to ensure the ongoing sustainability of the AOM Benefits Program;

(f) Recommends the operation fee that would be most appropriate to ensure the ongoing sustainability of midwifery practice groups;

(g) Comments on the need for COLA or other adjustments in the compensation system for midwives.

11. The Hay Group submitted a proposal in February of that year.[3] Following the RFP process, the Hay Group was retained to conduct a compensation review of midwives in Ontario. I led the project. This led to Hay Group's report dated June 2003, "Association of Ontario Midwives – Compensation Review"[4] which was subsequently updated in February, 2004.[5]

12. I brought to this project my knowledge of Ontario's public sector, including the health care sector and in particular the knowledge concerning the work and compensation of physicians, nurse practitioners and other staff at Community Health Centres as result of my above-noted consulting projects.

2. Report Summary

13. The Executive Summary to the Report states as follows:

The Hay Health Care Consulting Group was contracted by the Association of Ontario Midwives (AOM) to conduct a Compensation Review of Midwives in Ontario.

This report provides a summary of the activities conducted during our review, presents our findings and provides our recommendations on:

- *the appropriate level of compensation (current and ongoing);*

- *the percentage amount of the midwifery fee level necessary to sustain the AOM Benefits Program; and,*

- *the Operations Fee necessary to sustain the midwifery practice groups.*

Level of Compensation

3 2003/02/12 Hay Bid for Comp Review (February 12, 2003) AOM0005868.

4 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195.

5 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report AOM0001369.

We recommend that the compensation of Midwives be set at a single pay rate of $2,575 per BCC ($103,000 on an annual basis) as representing a level of compensation that compensates the profession of Midwives fairly. The single pay rate is broken down as follows:

"Base" rate $2,025/BCC or $81,000

"On-call" rate $550/BCC or $22,000

We further recommend that the job rate be maintained in accordance with the market by means of a cost of living adjustment on an annual basis.

Benefits Percentage

We recommend that the benefits percentage be increased from 16% to 20% of earnings.

Operations Fee

We recommend that, in order to determine the Operations Fee for 2003, an inflationary factor should be applied retroactively to the point of the last increase. In addition, on an ongoing basis, the Operations Fee should be adjusted annually by an appropriate inflationary factor.

Our findings and the basis of our recommendations are provided in the body of this report.[6]

3. Considerations and Principles

14. The Report set out our general considerations as follows:

It is our experience that the establishment of competitive, fair and equitable compensation is one of the critical factors necessary to attract qualified candidates and to retain experienced, valued practitioners.

In general, compensation programs should adhere to the following principles:

- *Ensure individuals are properly compensated for their contribution to fulfilling their professional requirements;*
- *Provide for internal equity among individuals performing the same function;*
- *Ensure competitiveness with the appropriate external market; and,*

6 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 at p.1-2.

• *Recognize unique working conditions.*

15. The Report also specifically noted the following considerations with respect to Midwives:

In developing our recommendations for this report, we wish to emphasize that the fair and appropriate compensation of Midwives is critical to ensure the continuation of the midwifery profession, in order to attract qualified individuals, reduce attrition and recognize the particular stresses that are attendant upon this group of professionals.

We note, in particular, that Midwives experience a high degree of stress resulting from lengthy periods of being on-call, 24 hours/day, seven days/week (including weekends and holidays).[7]

4. Summary of Activities

16. The various activities undertaken to conduct the compensation review were as follows:

(a) Project Planning

17. The report stated:

We commenced the project by conducting an initial meeting with the Steering Committee:

• *To confirm the scope of the project;*

• *To gain an understanding of the issues that formed the basis of the 1993 funding arrangements; and,*

• *To discuss our proposed approaches to structuring compensation and to determining the appropriateness of the benefit and operations fees.*[8]

(b) Confirming the Comparator Professions

18. The report stated:

An important issue, which forms the basis for the compensation review, is the confirmation of the comparator professions to be used for compensation comparisons. We framed this discussion for the Steering Committee in the context of establishing a compensation strategy.

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7 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 at p.1-2.

8 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 at p.3.

A compensation strategy establishes the framework of pay within which staff will be paid – i.e., how is the "market" defined and how competitive with the "market" should the pay levels be in order to attract and retain skills needed now and in the future. [9]

19. We "*discussed the answers to the following two key questions with the Steering Committee to formulate a compensation strategy for the Midwives:"*

Definition of Appropriate Market Comparators – Do the primary care nurses and family physicians in Community Health Centres (CHCs) continue to represent the most appropriate health care professions with which to compare compensation, or should other health care professions in other health care agencies be considered?

Definition of the AOM Pay Level Relative to the Market Comparators – Should the pay level be tied to the average of the market, toward the upper end (e.g., third quartile or 75th percentile) or toward the lower end (e.g., first quartile or 25th percentile of this market?

20. The Steering Committee concluded the following key points*:*

• The comparator professions include the Family Physician employed by CHCs and the Nurse Practitioner, which is a relatively new professional nursing category and was not in existence per se in 1993. (In 1993, the Primary Care Nurse position was considered the comparator nursing position in the CHC; this position is no longer funded by the Ministry of Health). However, the following key differences between these comparator professions and Midwives should also be taken into account:

– They do not have the requirement to work 24/7 on-call;

– They are salaried positions; and,

– Neither has fiscal responsibilities

It was also agreed that another physician model that could be considered a comparator is the fee-for-service model for family physicians who bill under OHIP.

• The market positioning should fall "somewhere" between the pay levels of a Family Physician and a Nurse Practitioner.[10]

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9 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 at p.3.

10 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 at p.3.

5. Gathering Market Data

21. We conducted the following activities to obtain current, relevant market data for comparison purposes:

(a) • Reviewed historical background documents related to the initial funding agreement in order to replicate how the compensation comparisons were made in 1993;

(b) • Investigated the cost of living adjustments (Consumer Price Index) over the past 10 years to examine what the Midwife compensation would have been if Midwives had received these adjustments;

(c) • Analyzed Hay's compensation database to examine the average year-over-year adjustments provided to public sector employees over the past 10 years to examine what the Midwife compensation would have been if Midwives had received these adjustments;

(d) • Analyzed Hay's hospital compensation database for compensation data on Nurse Practitioners; and,

(e) • We reviewed the Hay database and external data sources, and conducted a survey to examine on-call and call-in pay practices.[11]

6. Reviewing Benefits Fee Percentage

22. We conducted the following activities to obtain information on the allocation of the benefits percentage:

• Conducted a survey of organizations that employ part-time/contract health care professionals to examine the amount allocated to pay in lieu of benefits;

• Using Hay's method of assigning values to benefits, we calculated the dollar values of AOM's benefit package and compared it to the typical benefit package available to Nurse Practitioners in the hospital sector; and,

• Reviewed data provided by AOM's benefits consultant.[12]

7. Reviewing Operations Fee

23. We conducted the following activities to obtain information concerning the Operations Fee:

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11 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 at pp.3-5.

12 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 at pp.4-5.

• *Interviewed a variety of professionals who work independently or in small practice groups to determine whether there are any industry or sector benchmarks or guidelines for overhead/office expenses; and,*

• *Attempted to analyze the current operating expenses of Ontario Midwives in order to identify patterns in current expenses and potential areas of shortfall.*

8. Compensation Findings

(a) Our understanding of the 1993 Methodology

24. Our understanding of the considerations made in determining the 1993 compensation levels (setting the maximum rate for the Midwives at $77,000 per annum) include the following:

• *The Primary Care Nurse in a CHC was paid in a salary range from $42,000 (minimum of the range) to $56,000 (maximum of the range). A CHC Primary Care Nurse worked an average of 36 hours per week.*

• *The CHC Family Physician was paid in a salary range from $85,000 (minimum) to $123,000 (maximum). The salary range minimum and maximum both include a $5,000 per year on-call allowance. A CHC Family Physician worked an average of 36 hours per week.*

• *The Midwife worked an average of 44 hours per week.*

• *The maximum amount for the Midwife was set at $77,000, which represents 90% of the minimum amount paid to the Family Physician (but not taking into account the difference in the number of hours worked per week).*

• *The entry level for the Midwives was set at $55,000. When the 22% longer work week of the Midwife is taken into account (44 hours versus 36), the entry level of $55,000 is equivalent to $45,100 (which is 7% higher than the entry level of the Primary Care Nurse).*

• *When prorating the different hours of work, the Midwife enters the scale $3,000 higher than the minimum for the Nurse. Only at seven years does the Midwife reach the level of pay of the CHC Nurse at the top of the scale.*

• *After seven years of experience, the Midwife begins to earn more than the CHC Nurse for the same hours of work per week.*

• When the hourly compensation differences are considered, the top of the pay scale for the Midwife ($77,000) is much closer to the top of the Nurse's scale than to the bottom of the CHC Physician's scale.[13]

25. We observed the following in the above comparison approach:

• The top of the Midwife pay scale ($77,000) is 10% below the minimum of the Physician pay scale and 37% higher than the top of the Nurse pay scale ($56,000).

• When considering the difference in the number of hours worked per week, the top of the pay scale for the Midwife ($77,000) is 35% below the minimum of the Physician pay scale (equivalent to $103,888) and 13% higher than the top of the Nurse pay scale (equivalent to $68,444).

26. As well, we considered what the "adjusted" Midwife maximum salary level, assuming it had been adjusted annually rather than frozen since 1994.

The following two tables present the "adjusted" Midwife maximum salary level on a yearly basis, assuming this amount would have been adjusted annually over the past 10 years. Table 1 presents average year-over-year increases to salaries in the public sector (as reported in Hay's compensation data base. Table 2 presents average increases in accordance with annual increases in the Consumer Price Index (CPI).[14]

Table 1 – Hay Year Over Year Increase

Year	***Hay Ave. Year Over Year Increase***	***"Adj." AOM Salary***
1993	*0%*	*$ 77,000*
1994	*.080%*	*$ 77,616*
1995	*0.10%*	*$ 77,694*
1996	*0.20%*	*$ 77,849*
1997	*0.30%*	*$ 78,083*
1998	*0.90%*	*$ 78,785*
1999	*2.40%*	*$ 80,676*
2000	*2.80%*	*$ 82,935*
2001	*1.90%*	*$ 84,511*
2002	*2.50%*	*$ 86,624*

13 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p. 6-7.

14 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p. 7.

Table 2 – CPI Year over Year Increases

Year	*CPI Year Over Year Increase*	*"Adj." AOM Salary*
1993	*0%*	*$ 77,000*
1994	*0.20%*	*$ 77,154*
1995	*2.20%*	*$ 78,851*
1996	*1.60%*	*$ 79,009*
1997	*1.60%*	*$ 80,273*
1998	*0.90%*	*$ 80,996*
1999	*1.70%*	*$ 82,373*
2000	*2.70%*	*$ 84,597*
2001	*2.60%*	*$ 86,796*
2002	*2.20%*	*$ 88,706*

27. As shown above, the report stated that,

the 2003 maximum rate for the Midwives would have been $86,624 (an increase of 12% overall) based on Hay's compensation database and $88,706 (an increase of 15% overall) based on CPI information.

28. We then:

applied the same two annual increases to the CHC Family Physician's entry salary rate to illustrate what the minimum salary amount would have been in 2003 dollars had the same adjustments been applied. (The CHC Physician salary has not been adjusted since 1993).

The 2003 minimum salary rate would be $95,623 to $97,922 based on the increases in Hay's compensation database and the CPI, respectively.[15]

29. As well, we

also applied the same two types of annual increases to the CHC Nurse Practitioner, starting with 1999 when the position was initially introduced. The adjusted 2003 salary would be $75,160 to $75,382, respectively.

9. CHC Physician Model

30. To assist in making appropriate comparisons between the midwife and the CHC physician, we then considered the compensation arrangements for the CHC Family Physician which we found as follows:

15 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 pp7-8.

(a) • *Salaried employees, typically working a 35 hour work week*

(b) • *Key focus is to provide primary care*

(c) • *On-call 24/7; CHC receives compensation for on-call and allocates the money depending on whether there is shared on-call i.e., whether a Nurse Practitioner takes the call.*

(d) • *The salary ceiling (1993) for under-serviced areas is $135,830 and for fully serviced areas is $117,766.*

(e) • *CHC funds benefits – up to 20% of agency salary is provided for the cost of benefits (Although we cannot confirm this comment, we suspect that the 20% allocation is the minimum amount as it likely excludes costs for other benefits such as Workers Compensation*

(f) • *Typically 4 weeks of paid vacation is provided.*

(g) • *There is provision for continuing medical education.*

(h) • *CHC physicians are typically reimbursed for malpractice insurance costs.*

(i) • *There are no overhead costs.*

(j) • *Physicians are not restricted from billing fee for service outside of services performed in the CHC.*[16]

10. Recommendations

31. The Report provided the following recommendations for consideration in the establishment of competitive, fair and equitable compensation levels in components:

(a) **Establishing the "Job Rate"**

32. The Report states that the term "job rate" refers to the pay rate that a fully qualified incumbent would typically earn.

33. The Report provides two options for establishing a fair and equitable job rate for Midwives. (The options assume that the CHC data are "aged" to bring them to the equivalent of 2002 dollars).[17]

Option 1: Replicate 1993 Methodology

16 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p. 9-10.

17 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 pp. 9-10.

34. This option assumes that the same methodology used to establish the 1993 compensation is replicated as follows.

(a) *The proposed job rate is $86,000 ($2,150 per completed BCC), which represents 90% of the minimum amount paid to the CHC Family Physician based on a 35 hour work week, and including the on-call amount. (This proposed amount is virtually the same amount that the Midwife compensation would be if annual adjustments over the past ten years had been applied to the salary maximum.)*

(b) *This amount has been determined using the following assumption:*

(i) *The CHC Family Physician updated salary range data (using the more conservative type of annual increases) are $95,623 to $138,373, which includes the $5,000 per year on-call allowance. A CHC Family Physician works 35 hours per week.*[18]

Option 2: Reflect Proration of Hours Worked

35. This option is similar to Option 1, except that the proposed annual job rate has been prorated to reflect the difference in hours worked as follows:

(a) *The proposed job rate of $108,000 ($2,700 per BCC) represents 90% of the entry rate of the CHC Family Physician based on a 44-hour work week, including the $5,000 per year on-call allowance. This amount has been determined using the following assumption:*

(b) *The CHC Family Physician updated salary range data (using the more conservative type of annual increases) are $95,623 to $138,373 which includes the $5,000 per year on-call allowance. When the difference in hours worked per week is factored in, the entry rate becomes $120,212 and therefore, 90% represents $108,000.*

(b) **Factoring in On-Call Pay**

36. The Report also factored into its compensation recommendation and comparison the implications of On-Call Pay:[19]

The CHC Physician salary used for the basis of comparison in the above two options includes an on-call allowance of $5,000. However, this amount does not adequately reflect the onerous on-call schedule

18 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p. 17-19.

19 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p. 18-19.

necessitated by the midwifery model of care. The on-call schedule places considerable stress on Midwives.

We also note that other health care professions receive on-call premiums and that these premiums are typically higher for on call during weekends and holidays.

We therefore propose that an on-call premium amount be factored into our recommended job rate to recognize the significant amount of on-call time necessitated by the profession, which, to the best of our knowledge, is not a requirement of any other type of health care profession.

37. Based on information provided to us by AOM,

We calculated the on-call requirement to represent an average of approximately 4,400 on-call hours per year, based on the following:

• The number of days in a year that are "off-call" is 100 (includes 2 blocks of 28 days off, plus 12 three-day weekends and two 4-day weekends off).

• The total estimated number of hours worked per year for a full caseload is 1930 hours (40 BCC X 48.25 hours).

• The total remaining on-call hours, less the off-call time and time spent working, is 4,430 per year or approximately 110 hours per BCC.

38. The report therefore analyzed and calculated as follows:

The current Midwife compensation includes a portion that reflects on-call pay, by virtue of the CHC physician compensation including an annual $5,000 allowance. Using the above calculation of 110 on-call hours per course of care, this represents an average rate of $125/BCC or $1.14 per hour. Based on our research of on-call practices, this amount is clearly insufficient to recognize the amount of on-call for the Midwife, particularly when a high proportion of the on-call time takes place during nights, weekends and holidays. As stated above, many other professionals are paid a premium for off-regular hours.

To calculate the value of on-call hours for the Midwife, we have assigned an hourly rate of $5.00, or $550 per course of care ($5.00 x 110 hours) which we believe appropriately recognizes the amount and timing of on-call requirements for the Midwife. According to our market review, the proposed hourly rate is an approximate average of the regular and premium hourly on-call rates for nurses in Ontario.[20]

20 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 pp.18-19.

(c) Job Rate Recommendation

39. In light of the above, the Report recommended: [21]

> *that the appropriate job rate for Midwives is $2,575 per BCC, or $103,000 annually (based on an average of 40 BCCs per year). The job rate is broken down as follows:*
>
> *"Base" rate $2,025/BCC or $81,000*
>
> *"On-call" rate $550/BCC or $22,000*

40. We based our recommendation on the following considerations as stated in the Report:

> • *There is no exact market comparator for the profession of midwifery.*
>
> • *Based upon our independent review of the role descriptions of Midwives, CHC Nurse Practitioners and CHC Family Physicians, we conclude that the market for Midwives lies between the Nurse Practitioner and the CHC Family Physician, but closer to the Physician.*
>
> • *We believe that the 1993 methodology, which set the maximum rate for Midwives at 90% of the bottom of the CHC Family Physician range, is credible.*
>
> • *We used Option #1 as the "base" component and "backed out" the $5,000 on-call allowance portion.*
>
> • *We used Option #1 as the "base" component rather than Option #2 (which reflected 44 hours) because the Midwives are independent contractors similar to Physicians, who do not receive "compensation" based on the number of hours worked, nor do they receive vacation or sick pay.*
>
> • *We strongly believe that the onerous on-call requirements of the midwifery profession should be fairly and appropriately recognized in their compensation.*[22]

(d) **Maintaining the Job Rate**

41. The Report stated:

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21 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p. 19-20.

22 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p. 19-20.

Regardless which option is selected for the establishment of a pay scale, we recommend that the entire pay scale, or single job rate, be kept in pace with the market by means of cost of living adjustments. We therefore recommend the following:

> *• The pay scales, or single job rate should be reviewed once a year. Normally, all pay scales should be increased, depending on the movement of salaries in the market. This recommended increase for the total pay framework should be based on updated pay survey data and general trends in the economy or the community.*
>
> *• In addition to annual adjustments to pay scales, a periodic audit is recommended to ensure they are still in line with market levels and to ensure that the integrity of the pay plan is maintained. This should occur approximately every three to four years.*

(e) Benefits Percentage

42. The Report recommended that the benefits percentage be increased to 20% of earnings based on the following key considerations:

(a) *According to the cost analysis conducted by Larry Lenske (reported in the Findings section of this report), in order to maintain the same buying power in 2003 as in 1994, the 16% benefits funding would need to be increased by 25%, which translates into 20% of earnings.*

(b) *Our findings with respect to the value of the AOM group insurance benefit program demonstrates that the current level of benefits is between 16.5% and 23.2% lower than the market comparison on an annual basis. This analysis underscores the importance of not reducing the group insurance benefit levels as a means of cost savings.*

(c) *The value of the AOM pension plan is comparable to the market comparison.*

(d) *The above two comments with respect to the value of the AOM group insurance and pension program should be considered along with the following key difference between self-employed and employed professionals:*

> *− The Midwives have to pay for EHT, CPP and Workers Compensation while the employed professionals do not.*

43. We noted that the 20% benefits rate is consistent with the benefits rate of the Midwives' two key market comparators:

> *− It is the rate paid for the cost of benefits by CHCs for physicians; and,*

− *It is the rate funded by the Ministry of Health for Nurse Practitioners.*[23]

(f) ***Operations Fee***

44. The Report recommended that

In order to determine the Operations Fee for 2003, an inflationary factor should be applied retroactively to the point of the last increase. In addition, on an ongoing basis, the Operations Fee should be adjusted annually by an inflationary factor.

We were unable to conduct a comprehensive analysis of any required changes to the current Operations Fee. However, we believe that, at a minimum, the Operations Fee should be adjusted annually by an appropriate inflationary factor to appropriately reflect changes in the costs of operating a midwifery practice. In order to determine a rate for 2003, an inflationary factor should be applied retroactively to the point of the last increase.

Should you wish to continue to explore this area, we suggest two areas for further study:

1. Conduct an analysis of the most recent year-end operating statements of the Ontario practices. We believe that this study may identified under-funded areas of operations by providing a comparative analysis of the various items and the corresponding amounts that form the current expenditures of midwifery practices.

2. Conduct a survey of practices to identify operating activities that Midwives believe require additional funding support. These activities would be prioritized and costed. [24]

45. Following the publication of our report, we developed and delivered a power point to present our findings to the AOM.[25]

46. The Hay Group was not asked by the AOM and did not perform any specific analysis to determine whether the compensation and funding set by the MOHLTC for midwives complied with the *Pay Equity Act* or *Human Rights Code.*

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23 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p.23.

24 Association of Ontario Midwives – Compensation Review (June 2003) - Hay Group Report AOM0002195 p. 23.

25 PowerPoint Report by Hay Health Care Group re: Compensation Review Findings and Recommendations (May 28, 2003) AOM0002200.

III. HAY GROUP RESPONSE TO MOHLTC QUESTIONS CONCERNING JUNE, 2003 REPORT

47. I was advised in February, 2004 that the MOHLTC had questions concerning our June, 2003 Report. Accordingly, in response to those questions which were identified to me, we produced a document dated February, 2004, "Critique of Hay Group Report." [26]

48. This February, 2004 document addressed the MOHLTC critiques and our response as follows:

(a) *"Changing The Baseline Comparator from the Primary Care Nurse to the Nurse Practitioner".*[27]

49. Critique:

The Nurse Practitioner is not an appropriate base line comparator for midwives. If anything, the nurse practitioner position is comparable in many ways to the midwife in terms of scope of practice. Midwives compensation should be at the same level as nurse practitioners.

50. To this critique we responded that the Morton Report used the Primary Care Nurse at the time of its 1993 report as it was the most senior nurse position at the time. The nurse practitioner position did not formally exist at that time. Since that time, senior primary care nurses are Nurse Practitioners. Nurse Practitioners have a larger scope of practice than a registered nurse but they are still not comparable to a midwife as they work primarily under the supervision of a doctor. Midwives have a greater scope of practice in respect of the practice for which they are responsible. Finally, the CHC family physician was the primary comparator in 1993, and the Primary Care Nurse was merely a point of reference.

(b) *Estimating the CHC Physician Rate*

51. Critique:

The 2003 CHC Physician rate cannot be determined based on the Hay methodology of applying a cost of living factor. The 2003 physician rate should be considered as the rate which was in effect in that year, as this rate was used by CHCs.

52. To this critique we responded that "the fact that the MOHLTC had frozen CHC compensation rates for all employees during that time should not be used to

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26 "Critique of Hay Group Report" prepared by Hay Group (February, 2004) AOM0002240.

27 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369. p. 1.

penalize midwives and that "virtually all other health care providers in the province, including fee for service physicians had some form of cost of living adjustment during that time." "We feel that applying a cost of living factor to 1993 CHC physician rates is a conservative approach to establishing their 2003 rates as compared with the escalation of compensation for other health care groups over the same period, including fee for service physicians, nurses and therapists."

(c) Benefits[28]

53. Critique:

If midwives wish to be treated as self-employed practitioners, midwives should not receive additional compensation to pay for the cost of benefits. This would make pay practices more consistent with those of physicians and midwives in other jurisdictions, (i.e. British Columbia).

54. To this critique we responded that in theory the Hay Group had no issue with the concept of not paying additional compensation to cover benefits for independent contractors, but that their compensation should be recalculated and adjusted accordingly "to incorporate the cost of benefits on a go-forward basis. Either way, the cost of benefits needs to be recognized as a cost of 'doing business' as it was in the 1993 funding agreement".

(d) Determining the 1993 Job Rate

55. Critique:

the 1993 grid provided for 10 levels recognizing an annual compensation adjustment, not job competency. It was not based on a job rate equivalent to the highest level. It more appropriate to consider the middle level as the "job rate". Typical salary ranges provide for incumbents to reach the job rate in 3-5 years, not ten years".

56. To this critique we responded that it's true that typical salary ranges provides for incumbents to reach the job rate in 3-5 years and the 1993 agreement should have reflected that. However, "in view of the fact that the midwives were placed on the 1993 grid based on their years of service, it is more logical to conclude that the job rate is at the top of the range rather than at some point lower than the maximum."

28 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369 p.2.

(e) Determining the Number of On Call Hours [29]

57. Critique:

The approach for determining the number of on call hours is flawed. The methodology assumes that midwives are on call 24-7 when not on vacation or sick leave. This is an incorrect assumption. In fact, the number of on call hours varies based on the number of cases and whether a midwife practices in a group.

58. To this critique we responded that this was the information provided to us by the AOM.

(f) Determining the On Call Rate[30]

59. Critique:

The on call rate of $5.00 per hour is excessive

60. To this critique we responded that the proposed on call rate is based on market data for other health care comparators. "Indeed, inasmuch as a high proportion of the midwife's on call hours are 'premium' hours, like evenings, nights and weekends, we consider the proposed rate to be conservative."

IV. FEBRUARY 2004 UPDATED HAY COMPENSATION REVIEW REPORT

1. Request for Updated Report

61. We subsequently received a request from the AOM to prepare an updated version of our 2003 report, taking into account updated salary information up to 2003 (rather than 2002 as reflected in our 2003 report).

62. Accordingly, we carried out a further investigation to update the compensation information in our 2003 report. As a result, we revised our 2003 report to incorporate this updated information which also lead to a revision in our compensation recommendations. [31]

2. Revision to Compensation Recommendation

63. As a result of a salary increase to CHC physicians and the passage of a further year, the Report revised its recommended Level of Compensation (changes from 2003 report noted in brackets):

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29 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369 p.2.

30 "Critique of HayGroup Report" prepared by HayGroup (February, 2004) AOM0002240 p. 3.

31 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369.

We recommend that the compensation of Midwives be set at a single pay rate of $2720 per BCC (up from $2025) and $108,800 (up from $103,000) on an annual basis) as representing a level of compensation that compensates the profession of Midwives fairly. The single pay rate is broken down as follows:

"Base" rate $2,390/BCC (up from 2,025) or $95,600 (up from 81,000)

"On-call" rate 330 /BCC (down from $550) or 13,200 (down from $22,000)

We further recommend that the job rate be maintained in accordance with the market by means of a cost of living adjustment on an annual basis.[32]

64. The Report also adjusted the Tables of salary increases to include the 2003 year as set out below.[33] The 2003 report only included data to 2002.

Table 1 presents average year-over-year increases to salaries in the public sector (as reported in Hay's compensation data base). Table 2 presents average increases in accordance with annual increases in the Consumer Price Index (CPI).

Table 1 – Hay Year Over Year Increase

Year	***Hay Ave. Year Over Year Increase***	***"Adj." AOM Salary***
1993	*0%*	*$ 77,000*
1994	*.080%*	*$ 77,616*
1995	*0.10%*	*$ 77,694*
1996	*0.20%*	*$ 77,849*
1997	*0.30%*	*$ 78,083*
1998	*0.90%*	*$ 78,785*
1999	*2.40%*	*$ 80,676*
2000	*2.80%*	*$ 82,935*
2001	*1.90%*	*$ 84,511*
2002	*2.50%*	*$ 86,624*
2003	*2.50%*	*$ 88,790*

Table 2 – CPI Year over Year Increases

Year	***CPI Year Over Year Increase***	***"Adj." AOM Salary***

32 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369, p. 1.

33 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369, p.7.

1993	*0%*	*$ 77,000*
1994	*0.20%*	*$ 77,154*
1995	*2.20%*	*$ 78,851*
1996	*1.60%*	*$ 79,009*
1997	*1.60%*	*$ 80,273*
1998	*0.90%*	*$ 80,996*
1999	*1.70%*	*$ 82,373*
2000	*2.70%*	*$ 84,597*
2001	*2.60%*	*$ 86,796*
2002	*2.20%*	*$ 88,706*
2003	*2.00%*	*$ 90,480*

65. Accordingly, the Report revised the figures from the 2003 report to state that "the 2004 maximum rate for the Midwives would have been $88,790 (an increase of 15.3% overall) based on Hay's compensation database and $90,480 an increase of 17.5% overall) based on CPI information".[34]

3. Increase in CHC Physician Salaries

66. The Report under Heading CHC Physician model set out the increased physician salary: (prior salary in brackets)

> • *The salary ceiling (2004) for under-serviced areas is $150,419 (up from $135,830) and for fully-serviced areas is $127,971 (up from $117,766.[35])*

67. CHC physicians as of 2004 now earned a range of $106,216 to $127,971 in fully serviced areas and a range of $124,848 to $150,419 in underserviced areas. These numbers did not include on-call payment. With their increase in compensation, physicians also experienced a reduction in their on-call rates. This reduction is also reflected in the updated recommendations regarding midwives' compensation.

4. Job Rate Recommendations

68. The report recommended a revised job rate as follows:

We recommend that the appropriate job rate for Midwives is $2,720 per BCC, or $108,800 annually (based on an average of 40 BCCs per year). The job rate is broken down as follows:

34 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369, p. 8.

35 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369, p. 9.

"Base" rate $2,390/BCC or $95,600
"On-call" rate $330/BCC or $13,200

We base our recommendation on the following considerations:

- *There is no exact market comparator for the profession of midwifery.*
- *Based upon our independent review of the role descriptions of Midwives, CHC Nurse Practitioners and CHC Family Physicians, we conclude that the market for Midwives lies between the Nurse Practitioner and the CHC Family Physician, but closer to the Physician.*
- *We believe that the 1993 methodology, which set the maximum rate for Midwives at 90% of the bottom of the CHC Family Physician range, is credible.*
- *We used Option 1 as the "base" component and "backed out" the $5,000 on-call allowance portion.*
- *We used Option 1 as the "base" component rather than Option 2 (which reflected 44 hours) because the Midwives are independent contractors similar to Physicians, who do not receive "compensation" based on the number of hours worked, nor do they receive vacation or sick pay.*
- *We strongly believe that the onerous on-call requirements of the midwifery profession should be fairly and appropriately recognized in their compensation.*[36]

5. On Call Pay

69. With respect to this section, the Report made the following change:

To calculate the value of on-call hours for the Midwife, we have assigned an hourly rate of $3.00 or $330 per course of care ($3.00x 110 hours) which we believe appropriately recognizes the amount and timing of on-call requirements for the Midwife. However, we note that according to our market review, the proposed hourly rate ***is at the low end*** *of the regular and premium hourly on-call rates for nurses in Ontario.*

36 Association of Ontario Midwives – Compensation Review (February, 2004) – Hay Group Report, AOM0001369, p. 19.

V. HAY GROUP RESPONSE TO MINISTRY QUESTIONS RE: 2004 REPORT

1. Introduction

70. In July, 2004, I was advised that the Ministry had a number of concerns arising from our February, 2004 Report. Upon the AOM's request, the Hay Group, led by me, prepared the following response documents to address those concerns identified to us:

(a) "Elaboration on Information Provided in the Compensation Review prepared on behalf of the AOM, February, 2004" [37] which responded to various concerns which had been raised by the MOHLTC. [38]

(b) "Single Pay Rate for Independent Practitioners – Note Prepared for the Association of Ontario Midwives;" [39] and

(c) "Compensation Structure Options for Midwives".[40]

71. Below, I summarize the above-noted responses:

2. "Elaboration on Information Provided in the Compensation Review prepared on behalf of the AOM, February, 2004"

(a) Comparator Professions

72. MOHTLC Comment: The Ministry asked for more detail about the comparator professions such as in the form of a table comparing key attributes (similarities and differences) of midwives, nurse practitioners and CHC physicians that form the basis for determining appropriate compensation, including controlled acts, scope, responsibilities, risk and other relevant criteria.

Response:

In general terms we concluded that the market positioning for the Midwife should fall somewhere between the pay levels of a CHC family physician and a Nurse Practitioner. We found that, with respect to the birthing process, the Midwife has greater latitude with respect to controlled acts, scope, responsibilities and risk than the Nurse Practitioner, and less latitude as compared with the CHC Family Physician. For example, the Midwife, unlike the Nurse Practitioner, does not work

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37 "Elaboration on Information Provided in the Compensation Review Prepared on Behalf of the Association of Ontario Midwives, February, 2004" Hay Group (July 2004) AOM0002230.

38 "Elaboration of Information Provided in the Compensation Review prepared on behalf of the AOM, February, 2004 (July 2004) AOM0002230.

39 Single Pay Rate for Independent Practitioners – Note Prepared for the Association of Ontario Midwives". Hay Group (July 2004) AOM0001796.

40 "Compensation Structure Options for Midwives" Hay Group (July, 2004) AOM0002229.

under the supervision of a physician and has full authority to make care and treatment decisions. On the other hand, the Midwife's scope of practice is limited to the birthing process.

In addition to the above, we noted the following features of the CHC Family Physician and Nurse Practitioner roles, as compared with the Midwife:

They do not have the requirement to work 24/7 on call;

They are salaried positions; and,

Neither has fiscal (or management) responsibilities.

We should point out that it is possible that a full "job evaluation" of the three roles might indicate that the Nurse Practitioner is more closely aligned with the Midwife than the CHC Family Physician. The reason for this is that, in comparing the two positions, the Midwife has greater depth of responsibility within a specific area of practice, while the Nurse Practitioner has a greater breadth of responsibility with less scope of practice. In any event, in our study, we opted to replicate the 1993 methodology, which in our view is a credible approach.

(b) **Nurse Practitioner vs. BSN Nurse**

73. We noted that our report had reviewed role descriptions for the three positions but had not conducted a comprehensive analysis and comparison and could do so if requested.

74. MOHLTC Comment:

MOHLTC is questioning the choice of using the Nurse Practitioner as a comparator, rather than a Primary Care Nurse. According to the MOHLTC, PCNs still exist in CHCs, but they are called BSN nurses.

Response:

As noted in our report, the CHC "Primary Care Nurse" position, which was utilized in the 1993 review, is no longer in existence. We are not in a position to state whether this is the same position as the "BSN Nurse." We would have to compare the job descriptions of both positions.

It is our understanding that, at the time of the 1993 review, there were two nurse positions in CHCs. The Primary Care Nurse was the more senior position of the two, and it has since been eliminated in favour of the Nurse Practitioner position as the most senior nurses position. We selected the latter as the comparator position based on the understanding that it replaced the Primary Care Nurse position. We also selected the Nurse Practitioner position because the scope of practice for this position is closer to the Midwife than the typical baccalaureate prepared nurse found in Ontario health care organizations. In our view, the Nurse

Practitioner is therefore a more appropriate comparator position than the baccalaureate nurse.

(c) **Relating Midwife to CHC FP vs. NP** [41]

75. MOHLTC Comment:

MOHLTC is asking why we did not relate midwife compensation to the Nurse Practitioner, rather than the CHC Family Physician.

76. **Response:**

In our study, we found that the methodology utilized in the 1993 review was credible. In this methodology, the maximum pay level for the midwife was set at 90 per cent of the minimum amount paid to the CHC family physician. The Primary Care Nurse position was used only as a reference point. This methodology was duplicated in our report, so in essence it is irrelevant whether the nurse practitioner was used as a base-line comparator. Nonetheless, we continue to believe that the nurse practitioner is a useful comparator, but not as an equivalent.

Technically, it is possible to relate midwife compensation to Nurse Practitioner rates. To do so, we will have to determine an appropriate relationship

3. "Single Pay Rate for Independent Practitioners – Note Prepared for the Association of Ontario Midwives;" [42]

77. We responded to the concern raised about our recommendation for a single pay rate for the midwives as an independent practitioner. We highlighted the most crucial elements of our findings.

(a) Independent health care practitioners are all qualified practitioners. They have obtained through formal study the requisite qualifications to practice. For this reason, they do not practice under supervision.

(b) Further, independent practitioners bear approximately the same cost of doing business, regardless of their number of years of practice.

(c) As well, salary ranges are typically associated with salaried employees, and often account for a learning period, or are the product of unionization. These factors do not apply to midwives.

41 "Elaboration on Information Provided in the Compensation Review Prepared on Behalf of the Association of Ontario Midwives, February, 2004" Hay Group (July 2004) AOM0002230 p. 2.

42 Single Pay Rate for Independent Practitioners, Briefing Note by Hay Group (July 2004) AOM0002448.

(d) Additionally, many midwives have considerable experience prior to any kind of certification, and a stratified pay grid does not recognize that.

(e) We also provided a list of independent health care practitioners, including physicians, optometrists, chiropractors and dentists, all of whom are compensated in accordance with a single pay rate.

4. "Compensation Structure Options for Midwives"

78. We also provided an additional report to outline in more detail the compensation structure options MOHLTC might use to phase in the new compensation structure for midwives and alternative means to recognize experience while maintaining a single job rate.[43]

5. Follow Up

79. Our firm was not asked to engage in meetings or communications with the MOHLTC concerning these reports. The Hay Group was not contacted directly by the Ministry for any clarifications or information about these reports nor were we asked by the MOHLTC to provide any more detailed job analysis information.

VI. 2008 HAY REPORT: MARKET CHANGES IN CHANGES IN COMPENSATION 2005-2007

80. In 2007 the Hay Group was once again retained by the AOM. In particular, we were asked to prepare an updated document focused on changes to relevant compensation figures since our above-noted 2004 report.

81. Our 2008 report "Market changes in Compensation: 2005-2007"[44] found that during this timeframe, significant compensation increases were awarded to several professional groups including: nurse practitioners (average increase of 7.6%), registered nurses (8.2%), and physicians practicing obstetrics (11.3%).[45] It also noted that the CHC Physicians had also been provided with further compensation increases.

82. We noted that the larger increases for physicians and nurses reflected in the ONA and OMA agreements were obtained after the midwives' contract had been concluded. "Therefore, the benchmarks used for establishing annual increments within the contract period were based on… previous market experience,… rather than future known increases."[46] If the increases that were awarded to nurses and

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43 Compensation Structure Options for Midwives, Prepared by Hay Health Care Group (July 2004) AOM0002229.

44 "Market changes in Compensation: 2005- 2007" (2008) Hay Group AOM0000566.

45 "Market changes in Compensation: 2005- 2007" (2008) Hay Group AOM0000566.

46 "Market changes in Compensation: 2005- 2007" (2008) Hay Group AOM0000566 p 1.

physicians had been known to the AOM, the midwives may have been able to negotiate higher annual increments.

83. Note: Our calculations of the CHC physician compensation increases since 2003 in our AOM reports did not reflect in their compensation the incentive payments and other compensation related payments which were made to align their compensation with other primary care physicians as required by the OMA and MOHLTC agreements since 2003. Accordingly, if that were taken into account, the CHC physician compensation would be much higher.

VII. COMMUNITY HEALTH CENTRE HAY GROUP REPORTS

1. 1999 Hay Report Community Health Centres

84. In 1998, the Association of Health Centres of Ontario and the MOHLTC jointly engaged us to conduct a salary and benefits review of a variety of roles in the Centres.[47] It is my recollection that this was a joint project. It was funded by the MOHLTC who cooperated in providing data and information for the report. I was a lead consultant in this project as well.

85. The Hay Group conducted a job evaluation and salary and benefits market survey of broader public sector organizations that represent the market for CHCs.

86. This resulted in the Hay Group June, 1999 report for the Association of Ontario Health Centres "Association of Ontario Health Centres- Salary and Benefit Review Report".[48]

87. As part of the report, the Hay Group reviewed job documentation from various CHCs in order to identify jobs common to the CHCs. The Hay Group then assessed the value of those common jobs using its Hay Guide Chart-Profile Method of Job Evaluation which has four factors:

Know-How: This factor is used to measure the total of every kind of knowledge and skill, however acquired, needed for acceptable job performance. Three dimensions are considered: practical procedures and knowledge, specialized techniques, and learned skills; planning, coordinating, directing or controlling the activities and resources associated with an organizational unit or function; and active, practising, person-to-person skills in the area of human relationships.

47 MOH Community Health Centre Program Approved Salary Ranges 1994-1996 and portion of report from Hay Group CHC Report re salary and benefits AOM0001287.

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

Problem Solving: This factor measures the thinking required in the job by considering two dimensions: the environment in which the thinking takes place; and the challenge presented by the thinking to be done.

Accountability: This factor measures the relative degree to which the job when performed competently, can affect the end results of the organization or a unit within the organization. The opportunity to contribute to an organization is reflected through three dimensions: the nature and degree of the decision-making or influence of the job; the unit or function most clearly affected by the job; and the nature of that effect.

Working Conditions: This factor measures the context in which the job is performed by considering four dimensions: Physical Effort: Levels of physical activity that vary in intensity, duration and frequency that contribute to physical stress and fatigue. Physical Environment: Progressive degrees of exposure of varying intensities to unavoidable physical and environmental factors which increase the risk of accident, ill health or discomfort. Sensory Attention: Levels of sensory attention (e.g., seeing, hearing, smelling, tasting, touching) during the work process that vary in intensity, frequency and duration. Mental Stress: Progressive degrees of exposure of varying intensities of factors inherent in the work process which increase the risk of such things as tension or anxiety.[49]

88. The Hay Group proposed 9 job bands based on those rankings and used the bands to propose a salary range structure.

89. The study concluded that the 1994 salary ranges for the majority of CHC jobs which were set by the MOHLTC schedule (and not taking into account pay equity adjustments required by the *Pay Equity Act*) were below the market median, and that CHC staff compensation had not changed for eight years, with the exception of the Nurse Practitioner position. The report did not analyze the physician position as its compensation was set by the market.

90. CHC salaries had been frozen since 1994, apart from pay equity adjustments which had been funded by the MOHLTC. [50]

91. The Report concluded that the pay levels for CHC physicians were competitive with the market. At that time, Hay Group found that they were unable to provide market data for the Nurse Practitioner as a benchmark. Hay Group also noted

49 Association of Ontario Health Centres - Salary and Benefit Review Report, Hay Group (June, 1999) AOM0005885 pp. 22-23.

50 Association of Ontario Health Centres - Salary and Benefit Review Report, Hay Group (June, 1999) AOM0005885 p 8.

that a salary range of $57,000 to $70,000 had already been established by the MOHLTC for the RN (EC) position.[51]

92. Hay Group found that the 1994 Salary scales prior to pay equity were under market for all positions and they recommended increases. The report also recommended that pay equity be maintained by continuing to provide proxy pay equity adjustments at a minimum of one percent of payroll annually.

93. To conduct an analysis of the jobs relative to one another, we used our data systems, market data and job descriptions.

94. As experienced job evaluation experts, we are able to carry out job evaluation exercises using our own methodology, information, and investigation processes and relying on job descriptions and other research information concerning the job. This does not require the use of a questionnaire when our expert analysts are conducting the evaluations and can ensure the appropriateness of the job content information collected for the comparator positions.

95. Regarding CHC physician salaries, based on the data we had, we found that pay levels for CHC physicians were competitive with the market.[52] We also found that the job of the physician should not be rated in the same way as employees of CHCs, but should be "driven by market."[53] The CHC physician salary was not increased until 2003.

96. As a result of our investigations and assessment, our 1999 report proposed a new salary structure with an implementation cost at 6.2% of payroll.[54]

97. In July of 2003 the MOHLTC and the Community Health Centre Funding Budget Flexibility Committee, in conjunction with Hay Group, produced the Compensation Review Project Final Report, with new job descriptions and salary scales for Community Health Centres that flowed from the 1999 report.[55]

98. The primary goal of the report was to "recreate a standardized compensation program for all CHCs, to review and revise job templates for CHCs to guide the development of CHC specific job descriptions and to collect and disseminate

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

52 Association of Ontario Health Centres - Salary and Benefit Review Report, Hay Group (June, 1999) AOM0005885 at p. 37.

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

54 Association of Ontario Health Centres - Salary and Benefit Review Report, Hay Group (June, 1999) AOM0005885 at p. 31.

55 Ontario Community Health Centres Compensation Review Project Final Report (July 2003) MOH004717.

information regarding current benefit plans in CHCs". This required revising the existing generic job descriptions from the MOHLTC Community Health Branch 1991 Manual, "Employee Compensation in Community Health Centres".[56]

99. This report recommended an increase in the frozen CHC physician rates to the following: (North grid) $124,848 - $150,419 and the (South grid) $106,216 to $127,971. [57]

100. Up until 2003, we were working jointly for the Ministry and CHCs.

VIII. 2009 ASSOCIATION OF ONTARIO HEALTH CENTRES REPORT

101. Hay Group was subsequently retained by the Association of Ontario Health Centres to prepare a report: "Developing a Provincial Compensation Structure" dated July, 2009.[58] Again, I led this project. We were retained to establish the "compensation levels as a provincial sector in the new LHIN environment".[59]

102. Up to this time, the MOHLTC had established a provincial salary schedule for CHC positions. With the devolution of the CHCs to now be funded by LHINs, the provincial salary schedule was no longer mandated by the MOHLTC. Given these developments and the passage of time since the last review, it was timely to revisit the provincial structure.

103. The CHC Physician was not included in the analysis as the compensation for that position was set by the separately negotiated MOHLTC and OMA agreement.

104. Additional positions were added to the provincial salary schedule. We conducted a market survey of the CHC benchmark positions, including the Nurse Practitioner. We then proposed a new compensation structure based on 13 pay bands. The Nurse Practitioner and Psychologist were put in the same band 10. The Nurse Practitioner was proposed to have a new maximum job rate of $92,200.

IX. 2010 NURSE PRACTITIONERS ASSOCIATION OF ONTARIO REPORT

105. The Hay Group was also retained directly by the Nurse Practitioners' Association of Ontario (NPAO) in January 2011. I led that project as well. It resulted in our “Final Report Submitted to: Nurse Practitioners Association of Ontario,

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56 Ontario Community Health Centres Compensation Review Project Final Report (July 2003) MOH004717, p. 3-4.

57 Ontario Community Health Centres Compensation Review Project Final Report (July 2003) MOH004717, p. 9.

58 Hay Group Report to AOHC, AFHTO, NPAO: Developing a Provincial Compensation Structure for Primary Care Organizations (May 8, 2013) AOM0015462.

59 F Hay Group Report to AOHC, AFHTO, NPAO: Developing a Provincial Compensation Structure for Primary Care Organizations (May 8, 2013) AOM0015462, p. 1.

"Compensation Consulting Services", January, 2011. [60] The report addressed the "appropriate level of compensation for the Nurse Practitioner role."[61]

106. Our Methodology set out in Section 2.0 of the Report included working with a Project Steering Committee to review the methodology and confirm the professional roles against which to benchmark the Nurse Practitioner (NP) for relative job size and compensation. These were the Clinical Nurse Specialist, Family Physician, Pharmacist, Physician Assistant and Registered Nurse. Our review looked at job descriptions for the above roles and other documentation including a discussion paper written for the Ontario College of Family Physicians "Implementation Strategies: Collaboration in Primary Care – Family Doctors and Nurse Practitioners Delivering Shared Care". [62]

107. Using the Hay Group Method of Job Evaluation, a recognized job evaluation tool, and based on documentation collected we assessed the value of the NP role relative to the benchmark health care roles. Based on the results of that job evaluation process, we conducted a comparative analysis of the compensation of the NP roles relative to the comparable health care roles.[63]

X. 2013: PRIMARY CARE COMPENSATION WORKING GROUP (PCCWG) REPORT

108. In May 2013, the Hay Group prepared a report for the development of a common primary care compensation structure for the Primary Care Compensation Working Group (PCCWG).[64] This report addressed the following inter-professional primary care models in Ontario: Family Health Teams (FHTs), Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs), and Nurse Practitionerd Clinics (NPLCs). The PCCWG is comprised of representatives of the Association of Ontario Health Centres (AOHC), the Association of Family Health Teams of Ontario (AFHTO) and the Nurse Practitioners Association of Ontario (NPAO). Hay Group examined all health care roles in these structures with the exception of physicians.

109. Nurse Practitioners were identified as a market exception and evaluated as being comparable to the psychologist. We recommended that the clinical psychologist

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60 Hay Group Health Care Consulting Final Report to Nurse Practitioners Association of Ontario (NPAO) Compensation Consulting Services (January 1, 2011) AOM0007558.

61 Hay Group Health Care Consulting Final Report to Nurse Practitioners Association of Ontario (NPAO) Compensation Consulting Services (January 1, 2011) AOM0007558, p. 3.

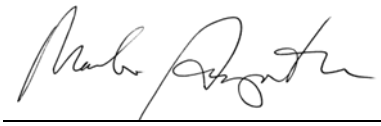
62 Hay Group Health Care Consulting Final Report to Nurse Practitioners Association of Ontario (NPAO) Compensation Consulting Services (January 1, 2011) AOM0007558, pp.4-5.

63 Hay Group Health Care Consulting Final Report to Nurse Practitioners Association of Ontario (NPAO) Compensation Consulting Services (January 1, 2011) AOM0007558, pp.4-5.

64 Hay Group Report to AOHC, AFHTO, NPAO: Developing a Provincial Compensation Structure for Primary Care Organizations (May 8, 2013) AOM0015462.

salary range apply to the Nurse Practitioner position, noting that this salary range maximum would be consistent with Hay Group's January 2011 report to the NPAO. [65]

SWORN this 27th day of July 2016.



Moshe Greengarten

A Commissioner for taking Affidavits

65 Developing a Provincial Compensation Structure (2009) MOH004712.