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Introducing Physician Assistants to Ontario

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Abstract

In 2006, the Ontario Ministry of Health and Long-Term Care (MOHLTC) introduced Physician Assistants (PAs) through the announcement of demonstration projects, education and training programs, and subsequent funding. PAs are directly supervised by physicians and act as physician extenders by performing acts as delegated to them by their supervising physicians. PAs were proposed as a potential solution to help improve access to health care and reduce wait times throughout the province. Prior to the 2006 Ministry announcement, there was little public discussion regarding the acceptance of the PA role or its sustainability. Opposition from nursing and other groups emerged in response to the 2006 announcement and flared again when stakeholder comments were solicited in 2012 as part of the PA application for status as regulated health professionals. As a health reform, the introduction of PAs has neither succeeded nor failed. In 2013, the majority of PA funding continues to be provided by the MOHLTC, and it is unknown whether the PA role will be sustainable when the MOHTLC withdraws salary funding and health system employers must decide whether or not to continue employing PAs at their own expense.

Le ministère de la santé et des soins de longue durée de l'Ontario (MSSLD) a introduit les Adjoints au Médecin (AM) en 2006 en annonçant des projets expérimentaux, des programmes de formation et d'éducation, ainsi que des financements à venir. Les AMs sont placés sous la direction directe des médecins et agissent comme des prolongements des médecins en effectuant des actes qui leur sont délégués par leur médecin superviseur. Les AMs ont été vus comme une solution possible aux problèmes d'accès aux soins et de délais d'attente dans la province. L'acceptabilité et la pérennité du rôle des AMs n'avaient pas vraiment été discutées publiquement avant cette annonce du ministère en 2006. Les infirmières, ainsi que d'autres groupes, ont marqué leur opposition en réponse à l'annonce de 2006, et de nouveau en 2012 lorsque des commentaires des parties prenantes ont été sollicitées dans le cadre d'un dépôt de demande de régulation en profession médicale par les AMs. L'introduction des AMs ne peut être qualifiée de succès ou d'échec. La majeure partie du financement des AMs est toujours assurée par le MSSLD en 2013 et il est impossible de savoir si le rôle des AMs sera pérennisé lorsque le MSSLD arrêtera de financer leur salaires, laissant les employeurs au sein du système de santé décider par eux mêmes s'ils veulent ou non continuer à employer des AMs sur leur propre budget.

Key Messages

- Physician Assistants (PAs) are a new health profession in Ontario, introduced as civilian health care providers in 2006 with significant financial support from the Ministry of Health and Long-Term Care.
- Physician Assistants (PAs) are not autonomous health professionals—their scope of practice is directly defined by their supervising physician(s) who retains responsibility and liability for acts delegated to the PA by the supervising physician.
- The future of Physician Assistants (PAs) in Ontario is uncertain, with Ministry funding in jeopardy and uncertainty from many health care system payers about how PAs can be used effectively to provide good care and value for money.

- *Les Adjoints au médecin (AM) forment une nouvelle profession de santé en Ontario, introduite dans le système de santé pour les civils en 2006, avec un soutien financier significatif du Ministère de la Santé et des Soins de Longue-Durée.*
- *Les Adjoints au médecin (AM) ne sont pas des professionels de santé autonomes—leur champ d'exercice est directement défini par leurs médecins superviseurs et ce sont ces derniers qui sont responsables et redevables pour les actes qu'ils délèguent aux AMs.*
- *L'avenir des Adjoints au médecin (AM) en Ontario est incertain, en raison de doutes sur le financement en provenance du ministère et d'interrogations de la part d'employeurs dans le système de santé sur la façon d'employer des AMs pour fournir des soins de qualité de manière coût-efficiente.*

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1 BRIEF DESCRIPTION OF THE HEALTH CARE REFORM

Physician Assistants (PAs) are a new civilian health profession in Ontario. They are not autonomous health professionals, but work under the direct supervision of a physician who delegates particular tasks to the PA, including controlled acts governed by the Ontario Regulated Health Professions Act, while assuming liability for that person's work. PAs were introduced in May 2006 as part of the new health human resources strategy of Health Force Ontario (HFO), an initiative of the Ontario Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Training, Colleges, and Universities. The announcement introduced PAs via a series of demonstration projects in different healthcare sectors across the province. This announcement also included information about the initiation of PA education programs in Ontario (MOHLTC 2006). Despite being new to civilian healthcare in Ontario, PAs are well established in the United States and the Canadian Forces.

While the initial demonstration projects ended in 2009, MOHLTC has continued to provide PA funding to employers through HFO under an evolving series of criteria. Funding is currently provided by HFO in the form of salary grants to support Ontario PA education program graduates who are employed in high priority settings (Health Force Ontario 2012), and as contract extensions to previously funded PA positions. The career start grants provide 50-100% of each PA's salary for two years, with matching funds to come from the employer. Over the past few years, this funding has been extended on a contract basis allowing further time to integrate the PA role but not contributing to long-term sustainability. The MOHLTC has stated in communications to PA employers and stakeholders that this financial support for PAs is time-limited, with current contracts ending in early 2015 (McGurn 2013). Aside from these grant programs, permanent funding for PA salaries has been provided to a small number of employers working in areas identified as high-priority: family health teams, patient enrolment model groups, and neurosurgical hospitals (McGurn 2013).

2 HISTORY AND CONTEXT

Physician Assistants are well integrated into health care teams in the United States, where they were introduced in the late 1960s (Larson and Hart 2007). In contrast, PAs are a relatively new addition to Canadian civilian health care, but have been trained and employed by the Canadian Forces for several decades (Jones 2012). As of 2012, there were about 125 military and non-military PAs working in Ontario (Jones 2012). PAs have also been introduced into civilian healthcare in other provinces: PAs are best established in Manitoba where they have been regulated since 1999. PAs are also employed through various ministerial initiatives in Alberta and British Columbia, with regulation and certification requirements still under consideration (Jones and Hooker 2011). PAs are not well established

internationally, with the exception of the US, although in the past ten years various countries have introduced PAs through demonstration and pilot projects, including Australia, South Africa, Taiwan, the UK, and the Netherlands (Gerrie and Holbrook 2013; Hooker, Hogan and Leeker 2007). Typically, PA demonstration projects have employed American-educated PAs while PA education programs, scopes of practice, and policies were being developed (Hooker and Kuilman 2011).

The PA scope of practice is unique from other health professionals as it varies depending on the individual physician-PA relationship. Each PA's scope of practice is defined by what has been delegated to them by their supervising physician and guided by a National Competency Profile that defines how and under what circumstances the PA may exercise their competencies (Mikhael, Ozon and Rhule 2007; Canadian Association of Physician Assistants 2009). The Scope of Practice and National Competency Profile were created with the support of The Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC). PAs are trained to take patient histories, conduct physical examinations, order and interpret tests, diagnose and treat illnesses, counsel on preventive health care, and may develop additional specialized skills while working with a supervising physician. Responding to an application for status as self-regulated health professionals, the Health Professions Regulatory Advisory Council (HPRAC) recommended in 2012 that Ontario PAs not be regulated at this time. Instead, it recommended a compulsory registry to be designed and administered by the College of Physicians and Surgeons of Ontario (CPSO) (HPRAC 2012).

There are two PA education programs in Ontario, delivered by McMaster University and the Consortium of PA Education (University of Toronto, Michener Institute for Applied Health Sciences and the Northern Ontario School of Medicine), each accredited by the Canadian Medical Association Conjoint Accreditation Services. Both programs offer an undergraduate degree and require at least two years of undergraduate study (in any discipline) to be admitted to the program. The third Canadian civilian PA education program is based at the University of Manitoba.

There is limited research evidence about the efficacy of PAs in any context, but most of what exists is primarily relevant to the American healthcare context, creating difficulty in finding generalizable, transferable evidence about PA performance that is useful to Canadian decision-makers (Doan et al. 2011; Halter et al. 2013; Kleinpell, Ely and Grabenkort 2008). Systematic reviews of evidence about PAs in the context of primary care, intensive care, and emergency care have demonstrated that most existing publications focus on describing the types of tasks and roles that PAs are employed in, and very little generalizable evidence is available about their efficacy at performing those tasks, impact on patient outcomes, or cost-effectiveness (Doan et al. 2011; Halter et al. 2013; Kleinpell, Ely and Grabenkort 2008). These systematic reviews comment on the difficulty of comparing or synthesizing the data that do exist, due to the heterogeneous contexts in which PAs work and the challenge of extracting PA data from that related to other health care providers.

3 GOALS OF THE REFORM

Health Force Ontario public communications about the PA demonstration project explicitly state the goals of the PA role are to lower wait times, increase access to care, achieve team and patient satisfaction, and improve team recruitment and retention. These goals were consistent with the overall plan for health innovation initiated by then-Premier Dalton McGuinty: keeping Ontarians healthy, reducing wait times, and providing better access to doctors and nurses.

Implicit goals of introducing PAs include freeing up physician time by re-allocating the routine and less complex aspects of medical practice to PAs, to allow physicians to use their time and expertise in a more effective way. This may allow more patients to be seen, and may also improve the quality of professional life of physicians. Re-directing physician time may also have the effect of lowering health care costs, since PA salaries are significantly less expensive than physician fees. This is an important goal; physician incomes are the third highest health care cost in Ontario, after drugs and hospitals.

4 FACTORS INFLUENCING THE HOW AND WHY OF

4.1 Getting on the agenda

The introduction of PAs appeared on the health care agenda with very little debate; PAs were positioned by the MOHLTC as part of a multi-pronged health human resources strategy to solve several complex problems, with debate and opposition appearing only after the May 2006 announcement of this reform.

MOHLTC reports from the early-mid 2000s identify several health human resources problems: a perceived shortage of physicians and other health professionals, long wait times to access certain types of health care, and a lack of health care services in rural and remote areas and in certain sectors such as long-term care, community mental health, and primary care. PAs were proposed by the College of Physicians and Surgeons of Ontario in 2004 as a potential solution to the physician shortage, and also mentioned as a solution to long emergency department wait times by the Canadian Association of Emergency Physicians in 2005. There is little information available about why the MOHLTC decided to move forward with this new profession and there was no forum for public debate or response prior to the 2006 announcement of the PA demonstration project.

The introduction of PAs was congruent with several other MOHLTC initiatives at the time (e.g., primary care reform, the creation of family health teams, a focus on appropriate training and employment of internationally trained health care providers, the development of a comprehensive nursing strategy, expansion of funding and support for nurse practitioners, and an increase in medical school enrolment), thus the political climate was generally receptive to this announcement of a new health profession in Ontario. After the announcement of the PA demonstration projects, there was strong opposition from nursing groups

who cited concerns about continuity of care, safety, and quality of care received from PAs. Physician groups were supportive of the initiative and released numerous public statements in favour of PAs. These opposition and advocate groups, as well as representatives from other health professions and potential PA employers, were most publicly active when stakeholder opinions were solicited for the PA application for status as self-regulated health professionals in 2012.

4.2 Final decision-making

The initial decision to introduce PAs was made by the MOHTLC, but the sustainability of PAs in Ontario relies on many different stakeholder groups. Stakeholder opinions have been mixed, with public statements from groups who are proponents (physician, chiropodist, podiatrist, dietician, respiratory therapist groups, Canadian Forces Health Services Group); opponents (nursing, midwifery groups, Ontario Coalition of Senior Citizens Organizations); and undecided or ambivalent (employers, physiotherapist groups).

In order to succeed in Ontario, PAs will require ongoing cooperation and collaboration from a range of stakeholders. Without this support, their integration into the Ontario health system will fail, regardless of merit. The MOHLTC has used their resources (legislative, financial, educational) to introduce PAs, in the hopes of securing the support of the other stakeholders so that the role can be self-sustaining. This has not yet happened, likely because many of the issues that need to be resolved are outside the control of the MOHLTC. For example, in personal communications, health care organization decision-makers tend to cite a lack of Canadian evidence about the efficacy and value of PAs as a major impediment to allocating organizational resources to fund PA positions.

The dominance of a medical model of care in Ontario is one factor that continues to influence whether the introduction of PAs will be sustainable. The design of the remuneration model in Ontario, which privileges the activities of physicians, makes it difficult for PAs to demonstrate their financial value to employers, in turn making it difficult for employers to commit to hiring PAs. Currently in Ontario, a physician supervising a PA cannot bill for services performed by the PA unless the physician is directly and actively involved in the care; thus, in hospital settings, the employer (i.e., the hospital) must find funding from the general operating budget in order to employ a PA. Some hospitals may find creative ways of recovering the cost of PA salaries, such as increasing the number of surgeries that can be performed in a day, but this may not be possible in all settings (Bohm et al. 2010). In some out-patient settings, PAs may be financially viable because the physician may be able to perform enough additional services to cover the salary of the PA. Comparatively, in the United States, Medicare, Medicaid, and a majority of private payers cover services delivered by PAs, typically at 85% of the physician's fee schedule (AAPA 2010). The public payers (Medicare, Medicaid, Tricare) remunerate PAs with a fee-for-service model; there is no requirement for the physician to be actively involved in patient care performed by a PA, or even to be physically on site (AAPA 2010). This funding model makes it easier for

a potential employer to evaluate the cost-effectiveness of PAs.

5 HOW THE REFORM WAS ACHIEVED (OR FAILED)

This reform has yet to be achieved or to fail. The initial policy instrument was a two-stage demonstration project, establishment of PA education programs, and a demonstration project evaluation report. After the demonstration projects ended, time-limited grants were released by the MOHLTC with clear instructions that they are intended to support organizations while they find self-sustaining funding for PAs. There is no data available on the number of PAs who are employed without MOHLTC funding and it is unknown whether current employers will find ways to continue to employ PAs should the MOHLTC funding end. The marker of success or failure for this health reform will be the eventual sustainability of PAs without salary support from the government.

6 EVALUATION

The demonstration project had a planned evaluation component. Each employer who received a grant to employ a PA was asked to collect data to facilitate this evaluation. The evaluation report was completed in December 2011 and is not currently available to the general public. Most of the data available in the evaluation report is qualitative, demonstrating patient satisfaction, reduced wait times in the emergency department, increased referral of hospital inpatients to home care, reduced sub-acute stays for Long-Term Care (LTC) residents, increased average daily billings for supervising physicians, increased acute care length of stay, and increased referral to acute care for LTC residents. Among health care professionals who worked with PAs, there was widespread support for the continuation of the PA role (HPRAC 2012). The evaluation report has not been useful for the decision-making activities of employers who may value additional quantitative data around patient outcomes, safety, and financial viability.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

An analysis of the strengths, weaknesses, opportunities and threats associated with the introduction of PAs in Ontario is presented from the perspective of the Ontario MOHLTC in Table 1.

Table 1: SWOT Analysis of the Reform from the Perspective of the MOHLTC

Strengths	Weaknesses
• The PA role is well established in the United States and represents a significant opportunity to ameliorate many of Ontario's identified health care human resources problems. • MOHLTC integration of PAs has been well received by physician groups and by individual health professionals who work directly with PAs.	• Ministry funding is likely not sustainable but many employers are reluctant to find internal funding for PAs, complaining of a lack of sustainable models for funding and remuneration. • Poor understanding and misinformation regarding PA scope of practice and role of medical directives curtail the potential of this profession.
Opportunities	**Threats**
• Physicians are generally enthusiastic and funding incentives are effective at directing PA services to areas with identified need. • Enrolment is good in the PA education programs. • Additional research opportunities exist to demonstrate patient satisfaction, PA role within interdisciplinary teams, impact on patient outcomes, etc.	• Opposition from other health care professionals who are uncertain of the quality and safety of care that PAs can provide as unregulated health professionals.

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9 FOR MORE DETAIL

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