



April 2026

Pressure Points: Strengthening and Retaining Canada's Nurse Practitioner Workforce

Findings from the 2025 National NP Retention and Recruitment Study

Full report

Dr. Erin Ziegler



CANADIAN
FEDERATION
OF NURSES
UNIONS



Canadian Federation of Nurses Unions

About the CFNU

The Canadian Federation of Nurses Unions (CFNU) is Canada's largest nurses' organization representing frontline unionized nurses and nursing students in every sector of health care — from home care and LTC to community and acute care — and advocating on key priorities to strengthen public health care across the country. We are relentless advocates for the health and safety of our members and the patients that we care for from coast to coast. Join us as we speak up for a stronger health care system and a better workplace for all nurses.

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

Published by:

Canadian Federation of Nurses Unions
2841 Riverside Drive
Ottawa, ON K1V 8X7
613-526-4661
www.nursesunions.ca

ISBN: 978-1-990840-62-3

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Message from the CFNU president

I first began advocating for nurse practitioners as president of the New Brunswick Nurses Union in the early 1990s, when a study found that nurse practitioners could adequately perform about 80% of a family doctor's scope of practice. To say that not everyone appreciated my perspective would be an understatement. It wasn't until the early 2000s that New Brunswick really introduced the role of nurse practitioners.

In the decades that have since passed, the understanding of nurse practitioners' scope and what that means for meeting the needs of patients in Canada has changed.

Newfoundland and Labrador were the trailblazers when it came to fast-tracking nurse practitioners. The province launched a program that would take nurses out of their community and provide the education they needed to return to their communities as primary care providers. Quebec and Nova Scotia soon followed suit. Ontario has long had the largest number of working nurse practitioners and was the first to implement NP-led clinics.

With funding from the federal government, in the early 2000s, the Canadian Nurse Practitioner Initiative developed a standardized framework for education and scope of practice that guides how nurse practitioners operate today.

One area that continued to need focus is equitable remuneration. In 2018, the Canadian Federation of Nurses Unions (CFNU) published a report that put the voices of nurse practitioners front and centre. This study was fueled by concerns from nurse practitioners and nurses' unions that NPs represented an untapped potential for how Canada could meet the growing need for primary care across the country. I remember non-unionized nurse practitioners who had to jump jobs frequently, playing musical chairs in the quest for work stability.

CFNU's report *Fulfilling nurse practitioners' untapped potential in Canada's health care system* recommended harmonizing NPs' salaries in all health care settings across

provinces and territories, enhancing employer benefit packages, adopting sustainable funding models to reflect the population's health needs, expanding and creating NP-led clinics, and including NPs in our governments' health human resources strategies.

While some of these recommendations have been implemented, there is still much work to be done. More than one in five Canadians do not have access to a nurse practitioner or family doctor — that's nearly six million people.

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The critical role that nurse practitioners have in primary health care is now widely recognized, and they are an integrated part of our public health care system — even if, from time to time, I do still have to remind politicians that access to primary health care includes more than doctors. A recent awareness campaign from the Registered Nurses' Union of Newfoundland and Labrador put this succinctly: "There's a nurse practitioner for that!"

Canada is now facing the largest change to how nurse practitioners operate in our health care system. The *Canada Health Act Services Policy* has come into effect as of April 1, 2026. First announced in early 2025 by the federal minister of health, this policy clarifies that medically necessary care provided by nurse practitioners is a part of Canada's public health care system, and access to these services must be based on medical need, not on ability to pay. This marks a milestone in ensuring the full scope of nurse practitioners' practice is understood, accepted and respected.

Now, with the help of Dr. Erin Ziegler and her team, the CFNU has a fresh report focused on nurse practitioners to offer policy makers and employers recommendations for how they can better respect, retain and recruit NPs in all areas of health care across our communities.

In solidarity always,



Linda Silas
CFNU President





Executive summary

Nurse practitioners (NPs) are a rapidly growing and essential component of Canada's health workforce, playing a critical role in improving access to high-quality patient-centred care across health care settings. At a time when one in five Canadians lacks a primary health care provider and health workforce vacancies remain well above pre-pandemic levels, optimizing NP recruitment, retention and role implementation is a national priority. This pan-Canadian mixed-methods study examined NP characteristics, practice environments, regulatory and organizational factors, and their influence on job satisfaction and workforce stability.

The study included 1,363 NPs from all provinces and territories, making it one of the largest and most comprehensive examinations of the NP workforce in Canada to date. While the NP workforce has more than doubled over the past decade, findings reveal growing strain within the profession. Overall, NPs reported being only *minimally satisfied* with their jobs. Satisfaction was highest for intrinsic aspects of practice: direct patient care, time with patients and clinical autonomy. However, dissatisfaction was widespread regarding compensation, lack of input into organizational decision-making, limited professional development opportunities, inadequate support for research and scholarship, and insufficient recognition of non-clinical contributions.

Retention concerns are significant. Over one-third of NPs reported thinking about or actively considering leaving their current position. The leading drivers of turnover and intent to leave were inadequate compensation, burnout and excessive workload.

Burnout emerged as a major post-pandemic issue, closely linked to unmanageable workloads, patient complexity, limited recovery time and organizational pressures. These conditions not only threaten NP well-being but also risk compromising quality of care. Compensation remains a critical challenge: salaries often fall below inflation-adjusted benchmarks, and funding models vary widely across jurisdictions, creating inequities and disincentives to hiring and retention.

Demographic shifts further complicate workforce sustainability. The rapid influx of novice NPs, combined with impending retirements of experienced practitioners, underscores the urgent need for structured transition-to-practice support, mentorship and succession planning. Without coordinated health human resource planning, Canada risks worsening workforce instability despite continued NP growth.

Key recommendations

- 1 Create positive NP work environments** by strengthening organizational policies and supports, ensuring reasonable workloads to reduce NP burnout, and enabling NP participation in professional development, research and decision-making about their roles.
- 2 Modernize remuneration and funding models** to ensure equitable, transparent and competitive compensation that reflects NP scope, workload and contributions across diverse practice settings.
- 3 Implement comprehensive health human resource planning,** including workforce forecasting, transition-to-practice programs, mentorship for novice NPs and strategies to retain experienced nurse practitioners.



Letter from the author

Investing in NPs through supportive work environments, fair compensation and strategic workforce planning is essential to sustaining Canada's health care system. Addressing these issues will strengthen NP retention, enhance access to care, and ensure a resilient workforce capable of meeting current and future population health needs.

Canada's health care system is at a critical crossroads. Persistent workforce shortages, widening inequities in access to care and the lasting effects of the COVID-19 pandemic have exposed both the strengths and vulnerabilities of our health human resources. Within this context, NPs have emerged as a vital and rapidly growing segment of the workforce, providing accessible, high-quality and patient-centred care in communities across the country. Yet, despite their expanding role and proven value, NPs continue to face systemic barriers that threaten their sustainability, well-being and retention.

The findings of this study paint a nuanced and compelling picture. NPs continue to derive deep professional satisfaction from providing direct patient care, building therapeutic relationships and practicing autonomously to improve health outcomes. At the same time, many report feeling undervalued, overextended and insufficiently supported by current organizational, funding and policy structures. The prevalence of burnout, concerns about compensation, limited opportunities for professional growth and lack of influence in decision-making are not isolated issues; they are systemic challenges that, if left unaddressed, risk undermining the stability of the NP workforce and the broader health care system.

Many of the factors that negatively affect NP job satisfaction and retention are modifiable.

Importantly, this report does more than document challenges, it identifies opportunities. Many of the factors that negatively affect NP job satisfaction and retention are modifiable.

When NPs are supported to work to their full scope in environments that value their expertise, the benefits extend beyond individual practitioners to patients, communities and the health system as a whole.

Creating positive work environments, aligning remuneration with scope and contribution, and implementing coordinated health human resource planning are achievable goals. Addressing these issues has the potential to improve NP well-being, strengthen retention and enhance patient access to timely high-quality care

This work is also grounded in the voices of NPs themselves. Through survey and interview data, NPs across Canada shared their experiences with honesty, insight, and a deep commitment to their patients and profession. Their perspectives underscore a central message of this report: when NPs are supported to work to their full scope in environments that value their expertise, the benefits extend beyond individual practitioners to patients, communities and the health system as a whole.

It is our hope that this report serves as a catalyst for action. Policymakers, employers, unions, professional associations, educators and researchers all have a role to play in shaping a sustainable future for NP practice in Canada. By investing in NPs not only as providers of care but as leaders, innovators and partners in system transformation, we can strengthen Canada's health care system and better meet the needs of the populations it serves. This report is offered as both evidence and invitation: evidence of the critical contributions and challenges of the NP workforce, and an invitation to work collaboratively toward solutions that ensure NPs are supported, valued and positioned to thrive, now and into the future.



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Project report

Context and overview

Canada's health workforce is the foundation of the health care system. Understanding that workforce, who and where they work, and what they are doing are important elements of workforce planning (Bourgeault, 2021). Poor health workforce planning results in higher costs, risks to patient safety and quality of care, and inequities (Bourgeault et al., 2021; Poghosyan & Carthon, 2017). Recent national workforce monitoring shows that health workforce vacancy rates remain significantly higher than pre-pandemic levels, underscoring persistent recruitment and retention challenges (Statistics Canada, 2025b). Nurse practitioners (NPs) are the fastest growing health care professional group in Canada (Canadian Institute for Health Information [CIHI], 2022). Understanding the factors that influence the supply, recruitment, utilization and retention of NPs is essential for effective workforce planning (Health Canada, 2024).

NPs in Canada are registered nurses who have completed advanced nursing education typically at the master's level or higher, accrued required hours of clinical experience and met regulatory exam requirements (Canadian Nurses Association, n.d.). NPs are a separately regulated class of nurses with the legislated authority to autonomously diagnose and treat illness, order and interpret diagnostic tests, prescribe medications and perform medical procedures (Canadian Nurses Association, n.d.). NP licensing

through regulatory bodies varies across the country, some provinces and territories use a general NP license, while others issue specialty-specific licenses such as primary health care, pediatrics, adult or neonatal. NPs practice in a variety of settings, including hospitals, primary health care, community settings (e.g., home care, northern nursing stations) and facilities (e.g., long-term care, correctional institutions). According to the Canadian Institute for Health Information (CIHI, 2024a), the NP workforce continues to expand, with a 9.5% increase in NPs employed in direct patient care between 2023 and 2024. Over the past decade, the NP workforce has more than doubled, rising from 1.1 NPs per 10,000 population in 2014 to 2.2 per 10,000 in 2023 (CIHI, 2024a).

The previous Canadian Federation of Nurses Union (CFNU) report *Fulfilling Nurse Practitioners' Untapped Potential in Canada's Health Care System* highlighted the growing pressures on Canada's health care system, including limited access to primary health care, an aging population, and capacity strain in acute and long-term care, presenting NPs as a proven yet underutilized solution (Little & Reichert, 2018). This report examines the principal factors hindering NP retention and recruitment nationwide, such as role clarity, remuneration, interprofessional dynamics and funding structures, and advances evidence-informed recommendations to guide governments and health systems in more effectively leveraging the value NPs bring to the health care system. At the time, it was the largest survey examining NP recruitment, retention and job satisfaction in Canada. Overall, NPs were satisfied with their clinical role and patient involvement. However, several factors were associated with job dissatisfaction and identified as having important implications for NP recruitment and retention. These factors included NPs' perceptions of inadequate salary and benefits, limited opportunity to contribute to organization policy and practice, poor access to continuing education, and excessive administrative work. In addition, over 26% of NPs reported not working to their full scope of practice due to poor role clarity and regulatory and organization barriers (Little & Reichert, 2018).

Health system changes impacting NPs

COVID-19 pandemic

Since completion of this initial survey, there have been significant changes that have influenced the implementation of NPs' roles, job satisfaction, recruitment and retention (Bryant-Lukosius et al., 2026). Chief among these changes are the long-term effects of COVID-19 pandemic, with growing health care provider shortages and poor access to care, resulting in increased stress and challenging work environments for NPs, and negative impact on their health (Ziegler et al., 2021). Recent evidence also points to rising levels of burnout among Canadian NPs, driven by workload intensity, limited autonomy and system pressures, all of which negatively affect job satisfaction and intent to stay (Heale, 2025a). Shifts to increased use of digital technology and virtual care during the pandemic are continuing to change how NPs work (Ziegler et al., 2023). International study recommendations about the impact of the pandemic emphasized the importance of improving NP practice environments in order to sustain and grow the NP workforce (Ziegler et al., 2021).

Funding and remuneration models

Since 2018, there have been substantial changes to NP funding models and remuneration in many provinces (Bryant-Lukosius et al., 2026). British Columbia has established a contracted funding model for NPs, which allows them to establish a new team-based care clinic or join an existing one, the aim being to improve access to primary health care (British Columbia Government News, 2024). In November 2023, Alberta announced its new payment program, which allows primary health care NPs to operate their own publicly funded practice at a remuneration rate of 80% of physicians' fees. To qualify for the funding, NPs must have a panel size of at least 900 patients and offer after-hour services (Government of Alberta, 2024). In July 2025, Saskatchewan established the Primary Care Nurse Practitioner Contract Program. NPs in this contract model will have 3-year contracts with the province as independent contractors (Government of Saskatchewan, 2025). These models aim to increase access to care and may be beneficial for improving NP job satisfaction and retention; however, their effectiveness with achieving these outcomes has yet to be evaluated (Bryant-Lukosius et al., 2026).

Scope of practice

The scope of practice for NPs across Canada has also changed in the last six years (Bryant-Lukosius et al., 2026). For example, significant steps were taken to expand the scope of practice for NPs in Quebec and in Ontario. In Québec, new legislation enacted in 2021 allowed NPs to be autonomous, expanded their scope of practice and enabled them to provide more comprehensive services to their patients (Sarasua & Kozakiewicz, 2021). In 2022, Ontario NPs' scope of practice was also expanded to allow them to order computerized tomography and magnetic resonance imaging scans (College of Nurses of Ontario [CNO], 2022), and in 2025 further expanded for NPs to order and perform the following procedures: defibrillation, cardiac pacemaker therapy, transcutaneous pacing and electrocoagulation (CNO, 2025). There have also been expansions to the range of circumstances in which NPs are authorized to complete a medical certificate of death (CNO, 2025). These are changes that were intended to enable NPs to provide more comprehensive and timely direct care for their patients. Follow-up evaluation is needed to determine if these regulatory enhancements have achieved their intended impact on NP practice, patient access and quality of care.

NP job satisfaction

Job satisfaction among NPs is influenced by multiple factors, including autonomy in practice, professional recognition, workload and the ability to practice to full scope. NPs who perceive strong alignment between their roles and their training are more likely to report higher job satisfaction (Poghosyan et al., 2017). However, systemic challenges such as role ambiguity, lack of administrative support and poor organizational culture can undermine this satisfaction (Fournier et al., 2022; Heale, 2025a). A lack of competitive salaries and benefits, as highlighted in the CFNU report (2018), was a significant concern, contributing to decreased job satisfaction among Canadian NPs.

Intent to stay

The intent to stay in the profession is closely linked to job satisfaction and working conditions. Studies indicate that NPs who feel supported by their organizations, have access to continuing education and experience opportunities for professional growth are more likely to remain in their roles (Fournier et al., 2022; Poghosyan et al., 2017). Conversely, perceived job insecurity, excessive workloads and lack of professional development opportunities are associated with higher turnover intentions (Fournier et al., 2022).

The recruitment and retention of NPs are critical given the growing demand for primary health care providers. One in five (or 20%) of Canadians lack a primary health care provider, thus heightening the need to strengthen the recruitment and retention of NPs in this health sector (CIHI, 2024b; Duong & Vogel, 2023). Targeted interventions, such as competitive compensation packages, improved work-life balance and enhanced support for professional development, are necessary to ensure NPs' long-term commitment to their roles.

Challenges in NP retention and recruitment

The 2018 CFNU report identified several barriers to NP retention, including inadequate remuneration and administrative burdens. Role clarity and the ability to practice to full scope were also notable concerns (Little & Reichert, 2018). The shift towards digital technology and virtual care has introduced both opportunities and challenges. While telehealth has expanded access to care, it has required NPs to adapt quickly, often with limited training and support, leading to stress and uncertainty (Charalambous et al., 2024). Research in the United Kingdom found a decline in NP job satisfaction post-COVID related to exhaustion, workload and staffing issues (Wood et al., 2024). Another study found that NPs who reported higher levels of influence in and commitment to their place of work were more satisfied with their jobs (Duignan et al., 2024). Identifying how these and other factors impact NP job satisfaction is essential to improving recruitment and retention within the health care sector.

Demographic shifts

In addition, it is also important to understand the impact of demographic changes to the Canadian NP workforce on role implementation, recruitment, retention and job satisfaction. Since 2016, the size of the NP workforce has doubled to 10,790 NPs in 2024 (Nurse Practitioner Association of Canada [NPAC], 2024; CIHI, 2024c). Updated CIHI workforce data from 2024–2025 confirm this rapid growth, noting continued expansion across all provinces and a particularly high concentration of novice NPs entering diverse practice settings (CIHI, 2025). Thus, there are many more novice NPs working in a broader range of practice settings that may have limited experience in implementing NP roles.

The current study

Study aim

The purpose of this study was to examine NP characteristics, practice setting factors, and regulatory and organizational policies that may influence NP role implementation, job satisfaction, and recruitment and retention.

Methods

An explanatory sequential mixed-methods study was conducted in two phases to examine NP role implementation, job satisfaction, recruitment and retention in Canada. Eligible participants were NPs currently practicing in Canada, who could communicate in English or French. Research Ethics approval was obtained from Toronto Metropolitan University Research Ethics Board and McMaster University.

Phase 1 involved the administration of an updated version of the questionnaire used in the previous CFNU Pan-Canadian NP Retention and Recruitment study (Little & Reichert, 2018). The questionnaire included closed-ended items capturing NP characteristics such as age, gender identity, ethnicity, areas of practice and practice experience. Data on work-related factors, including recruitment, retention, work-life balance and continuing education, were also collected. Job satisfaction was measured using the Misener Nurse Practitioner Job Satisfaction Scale (Misener & Cox, 2001), a validated tool that supports comparison of job satisfaction trends over time and across future evaluations.

The survey was administered online. Recruitment took place through collaboration with the CFNU, national and provincial NP associations, targeted social media strategies and outreach to the research team's networks. At survey completion, participants were asked whether they were willing to be contacted for a follow-up interview in Phase 2.

Phase 2 consisted of a qualitative descriptive study involving interviews to explore, in depth, the factors that shape NP job satisfaction, role implementation, recruitment and retention. Findings from Phase 1 informed the prioritization of interview topics and guided sampling decisions to ensure diversity in practice settings, organizational contexts and provincial/territorial jurisdictions. Semi-structured interviews (30-45 minutes) were conducted via Zoom. Interviews explored participants' experiences and perceptions regarding factors that influence NP retention and recruitment in Canada. All interviews were audio-recorded with consent and transcribed verbatim by a professional transcriptionist.

Findings

Characteristics of study participants

Geographic distribution, demographic data and practice context

A total of 1,363 NPs representing all provinces and territories participated in the study, with a national response rate of 14% (Table 1). The majority of NPs held licensure in Ontario (47%), followed by Quebec (10%), Alberta (9%) and British Columbia (8%). NPs from Saskatchewan, Manitoba and the Atlantic provinces each made up 2–4% of participants, with small proportions from the Northwest Territories, Nunavut and Yukon (0.1–1%).

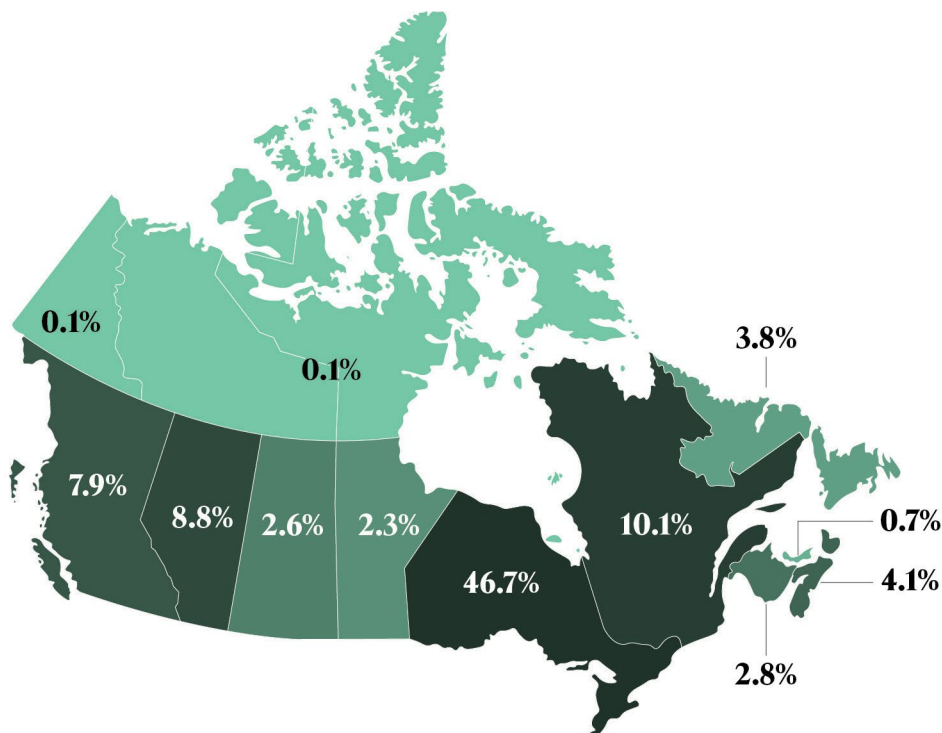


Table 1: Survey respondents

Respondents by province/ territory* (n = 1,363)	n	%	Number of NPs in province/territory**	Response rate for province/territory (%)
Alberta	120	8.8	680***	17.7
British Columbia	107	7.9	961	11.1
Manitoba	31	2.3	363****	8.7
New Brunswick	38	2.8	219	17.4
Newfoundland and Labrador	52	3.8	290	17.9
Northwest Territories and Nunavut	2	0.1	87***	2.3
Nova Scotia	56	4.1	360	15.6
Ontario	639	46.9	4,493	14.2
Prince Edward Island	10	0.7	76	13.2
Quebec	138	10.1	1,655	8.3
Saskatchewan	35	2.6	267	13.1
Yukon	1	0.1	21	4.8
Licensed in multiple provinces	134	9.8	n/a	
All provinces	1,363	100.0	9,464	14.4

*Respondents were asked to select all the provinces in which they were licensed to practice.

**Estimated number based on most recent data from Canadian Institute for Health Information, Nursing in Canada, 2024 — Data Tables. Ottawa, ON: CIHI, 2025. <https://www.cihi.ca/sites/default/files/document/nursing-in-canada-2015-2024-data-tables-en.xlsx>. College of Registered Nurses of Manitoba, Five Key Stats from this Quarter (April-June 2025), 2025. <https://www.crnmb.ca/wp-content/uploads/2025/09/2025-Q2-Quarterly-Report.pdf>

***Most recent data for Alberta, Northwest Territories and Nunavut are from 2023.

****Most recent data for Manitoba are from 2025.

Details about the demographic characteristics of study participants are found in [Table 2](#). The majority of NPs were female (92%), white, and on average 45 years of age. Most NPs (71%) practiced in urban communities, followed by rural (26%) and remote (3%) environments. The majority of participants provided NP services in English (78%), and 15% were bilingual, providing services in French and English.

Table 2: Demographics of survey respondents		
Gender (n = 1,363)	n	%
Man	94	6.9
Woman	1,254	92.0
Non-binary	3	0.2
Transgender woman	1	0.1
Prefer not to answer	11	0.8
Age (n = 1,363)		
Range	27-74	
Ethnicity* (n = 1,363)	n	%
Black	26	1.9
East Asian	38	2.7
Indigenous	44	3.2
Latin American	13	0.9
Middle Eastern	7	0.5
South Asian	39	2.8
Southeast Asian	21	1.5
White	1,156	84.8
Prefer not to answer	31	2.2
Other	34	2.4

Table 2: Demographics of survey respondents

Languages spoken (n = 1,342)		
	n	%
English	1,046	77.9
French	52	3.9
Bilingual (English/French)	200	14.9
Bilingual (English/other language) or multilingual	44	3.3
Highest level of nursing education (n = 1363)		
	n	%
Diploma	5	0.4
Baccalaureate	96	7.0
Master's	1,199	88.0
DNP	36	2.6
PhD	26	1.9
Other	1	0.1
Years worked as an RN prior to becoming an NP (n = 1,335)		
Range	0-37	
Years worked as an NP (n = 1,335)		
Minimum	0	
Maximum	32	
Mean (SD)	9.4 (6.9)	
Years experience as an NP (n = 1,335)		
	n	%
0-1 year	148	11.1
2-3 years	212	15.9
4-5 years	150	11.2
6 years or more	825	61.8
*Respondents could select more than one response		

Education, licensure type and work experience

Most participants held a master’s degree (88%) (Table 2). The most common type of license that NPs held was primary care/family/all ages (84%) followed by adult/adult-gerontology (12%), pediatric (2.5%), neonatal (1.2%), and mental health (1.0%). Participants had substantive work experience as RNs prior to becoming NPs (mean = 10.3 years, SD = 5.9) and on average over 9 years work experience as NPs. However, less experienced NPs (≤ 3 years of NP work) accounted for 27% of participants.

Participants currently working as NPs

Most participants (n = 1,343) were currently employed as NPs, with the majority (95%) reporting their primary employment as clinical practice, with smaller proportions in faculty, administrative and research roles (Figure 1). Participants in clinical practice spent the largest proportion of work time providing clinical care (mean = 83%, SD = 19), with smaller proportions of time dedicated to leadership, education, advocacy and scholarship.

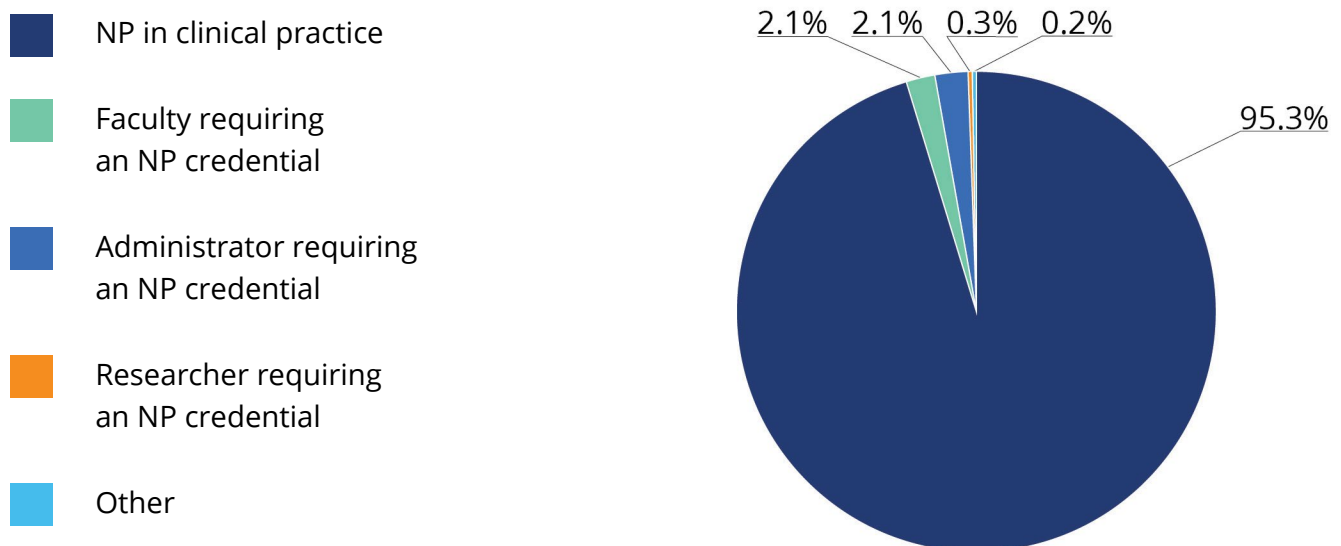
Table 3: Characteristics of current NP practice

Percentage of time spent in each domain of NP practice (n = 1,286)	Min	Max	Mean (SD)
Clinical	5	100	83.0 (19.1)
Advocacy	0	75	3.1 (5.4)
Leadership	0	85	5.7 (10.6)
Scholarship	0	70	2.6 (5.8)
Education	0	90	5.6 (10.0)
Length of time in current position (n = 1,219)	Min	Max	Mean (SD)
Number of years	0	27	5.3 (5.3)

Table 3: Characteristics of current NP practice

Panel size (n = 450)	Min	Max	Mean (SD)
Number of patients	5	3,800	514.2 (389.4)
Patients seen in a day (n = 1,270)	Min	Max	Mean (SD)
Number of patients	1	80	12.1 (6.1)
Time spent providing virtual care (n = 1,289)	Min	Max	Mean (SD)
Percentage of time	0	100	15.9 (21.7)

Figure 1. Primary employment as an NP (n = 1,312)



Characteristics of current NP practice

Figure 2. Type of NP position (n = 1,243)

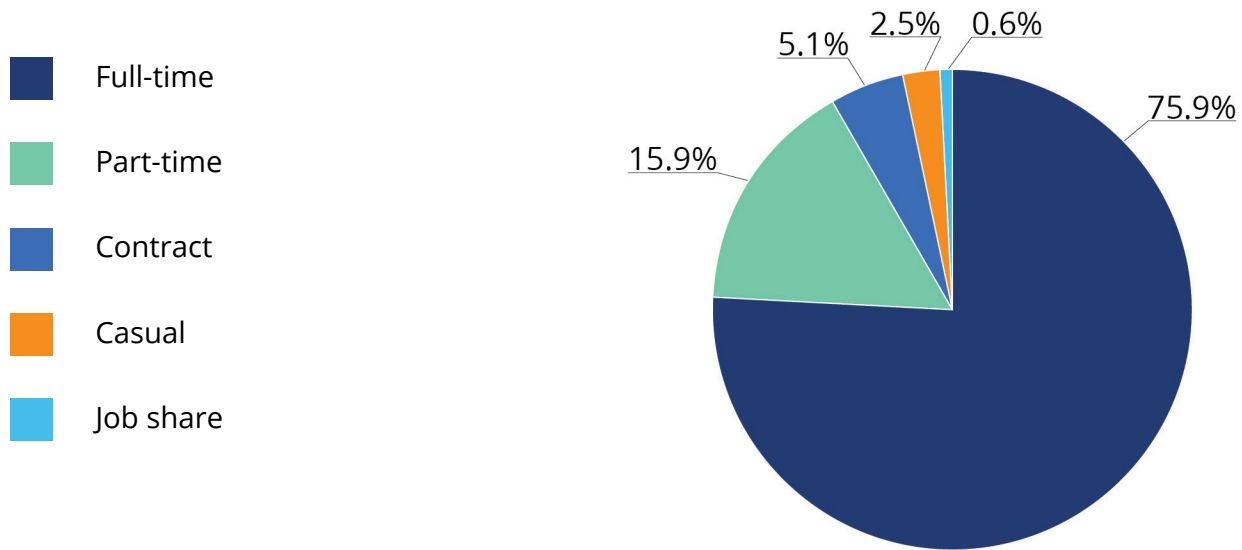
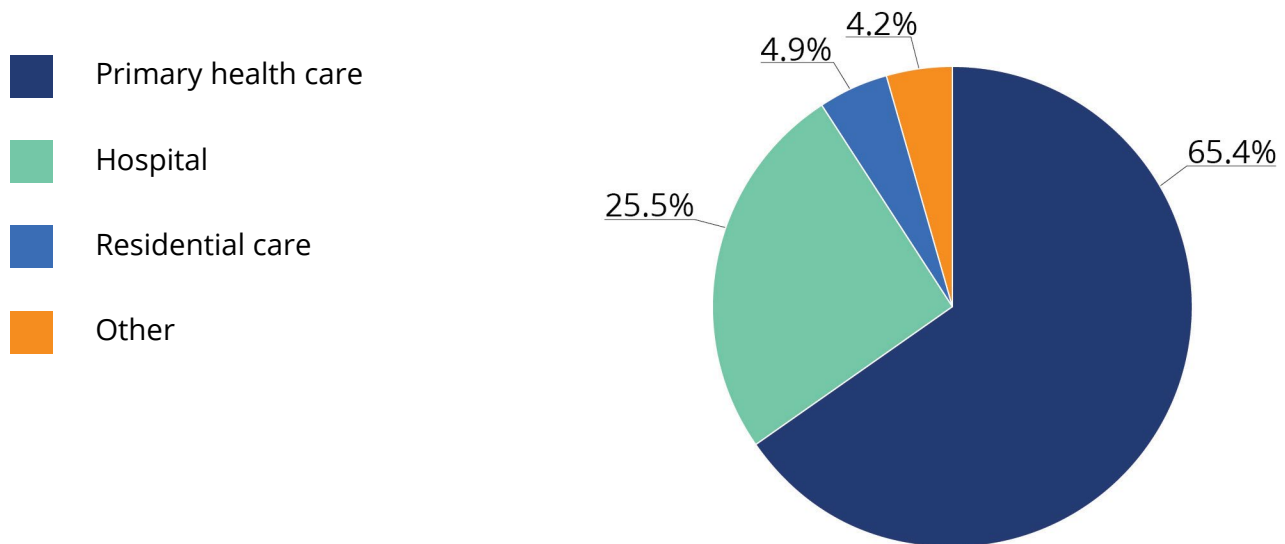


Figure 3. Type of practice setting (n = 1,312)



Characteristics of current NP practice

Figure 4. Region type (n = 1,363)

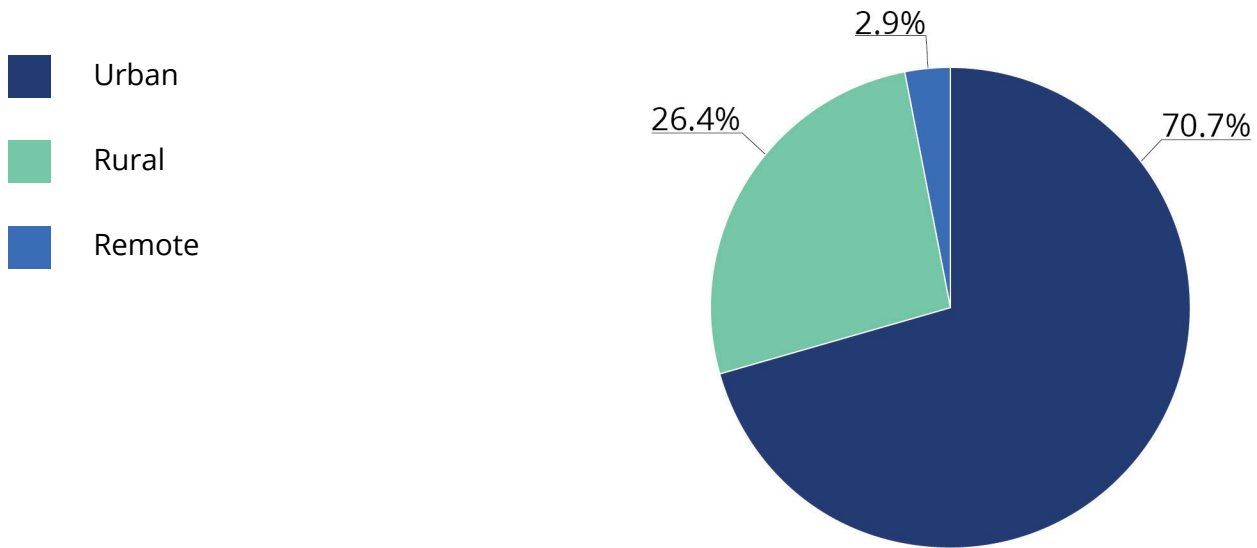
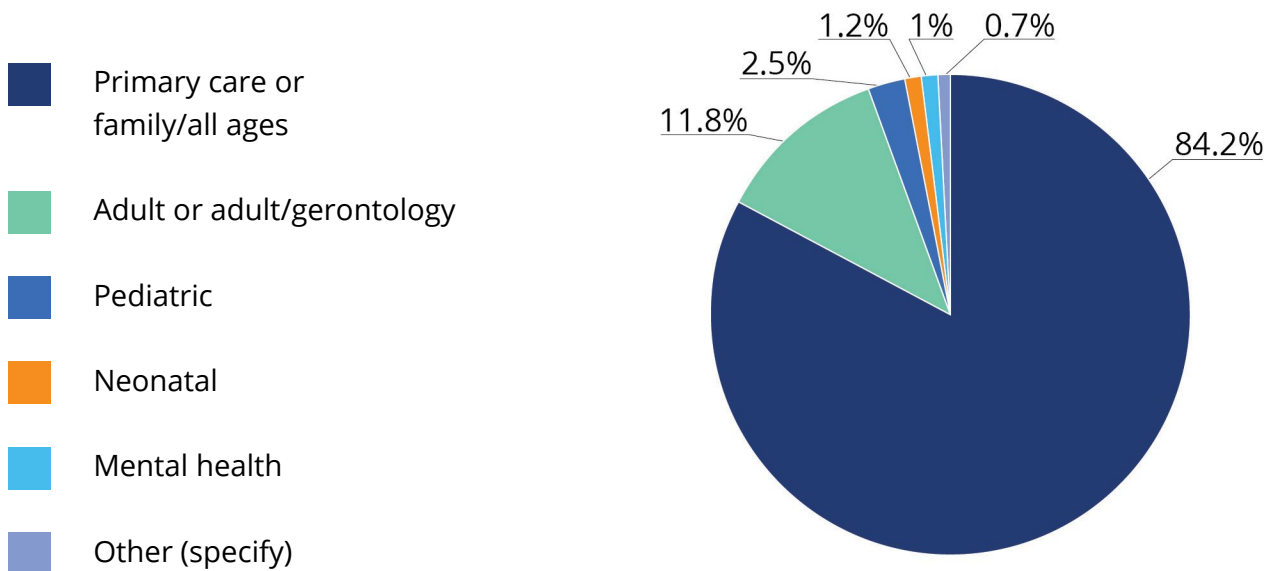


Figure 5. Type of NP license* (n = 1,363)



*Respondents could select more than one response

Characteristics of current NP practice

Figure 6. Patient population (n = 1,289)

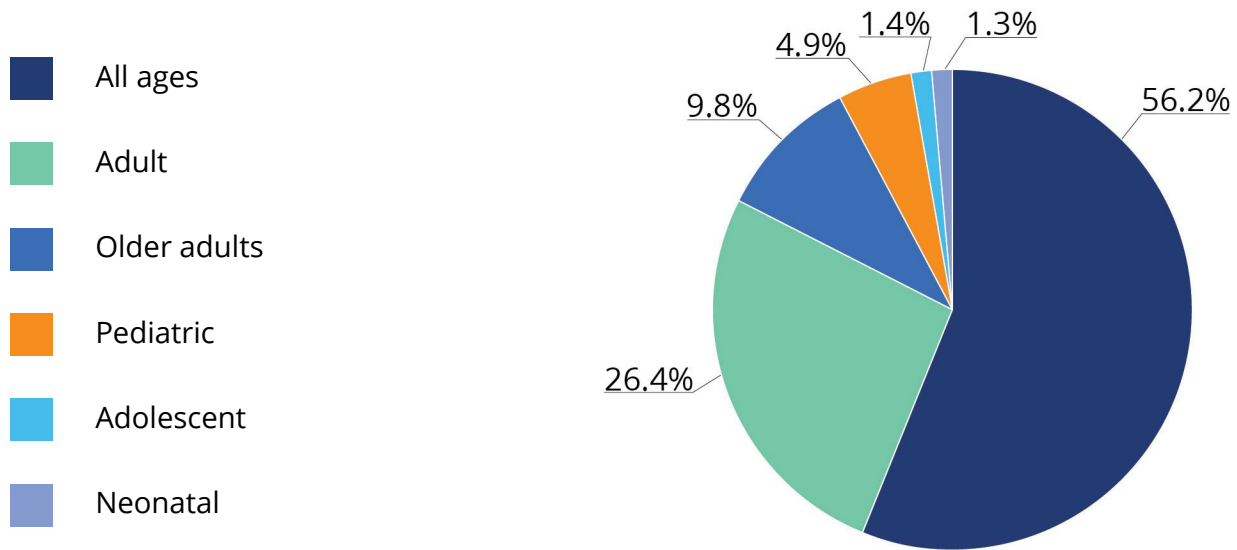
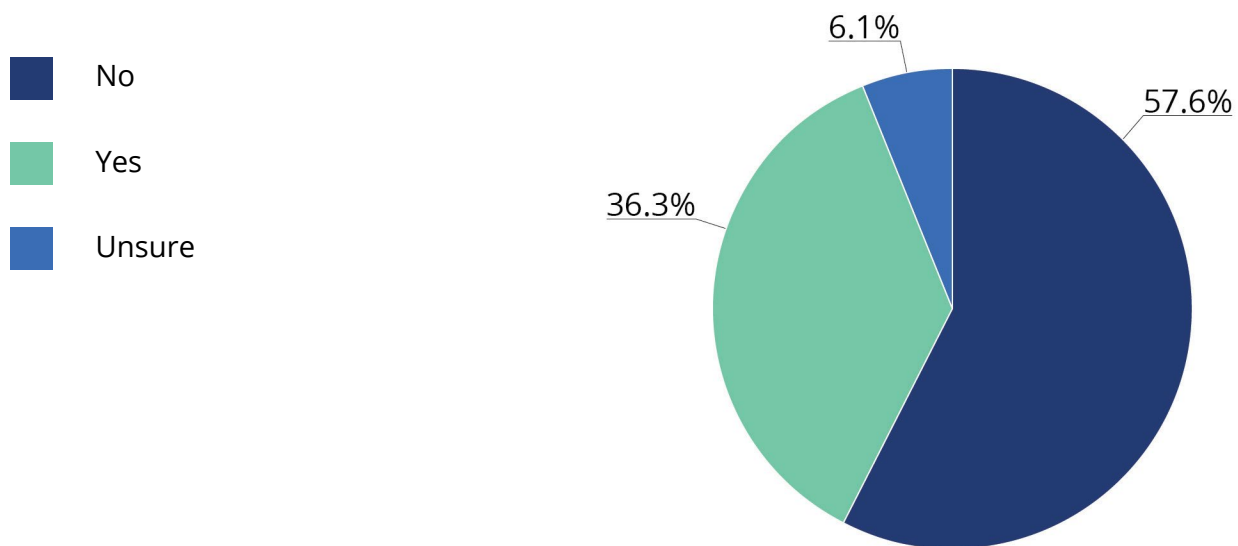


Figure 7. Management of a patient panel (n = 1,289)



Characteristics of current NP practice

Figure 8. Manageability of patient workload (n = 1,289)

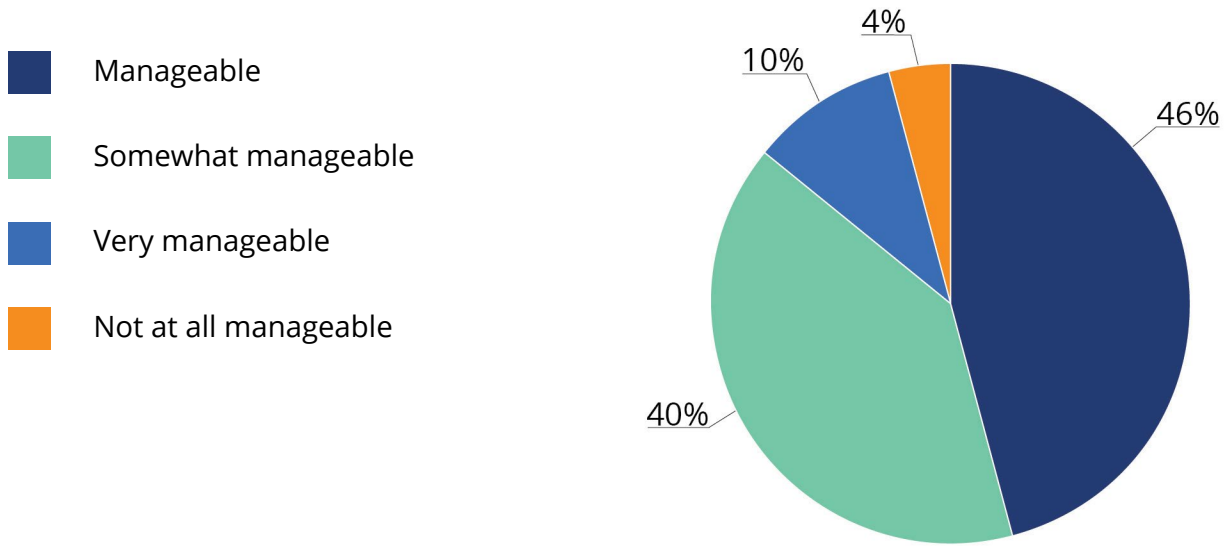
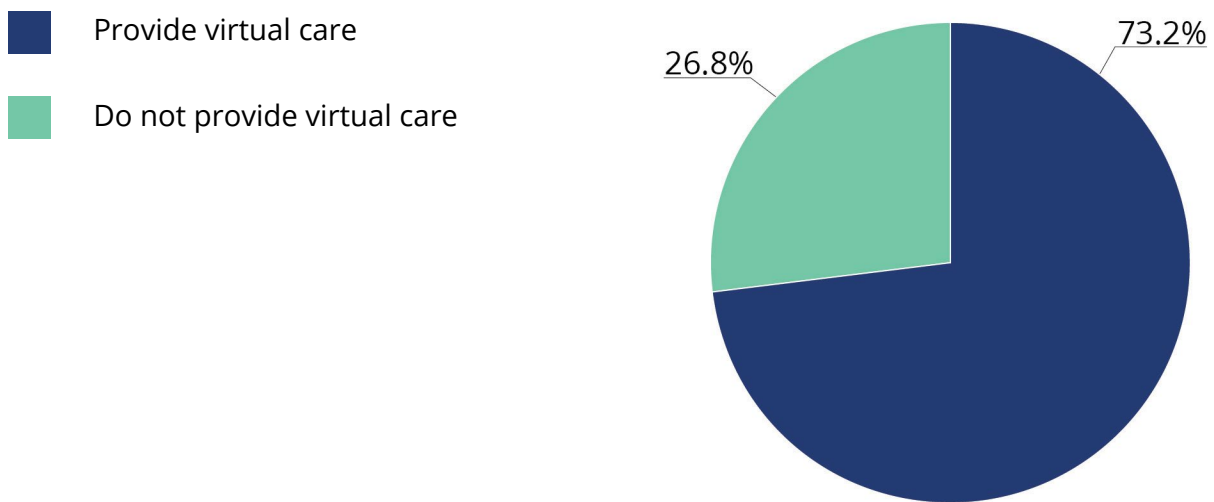
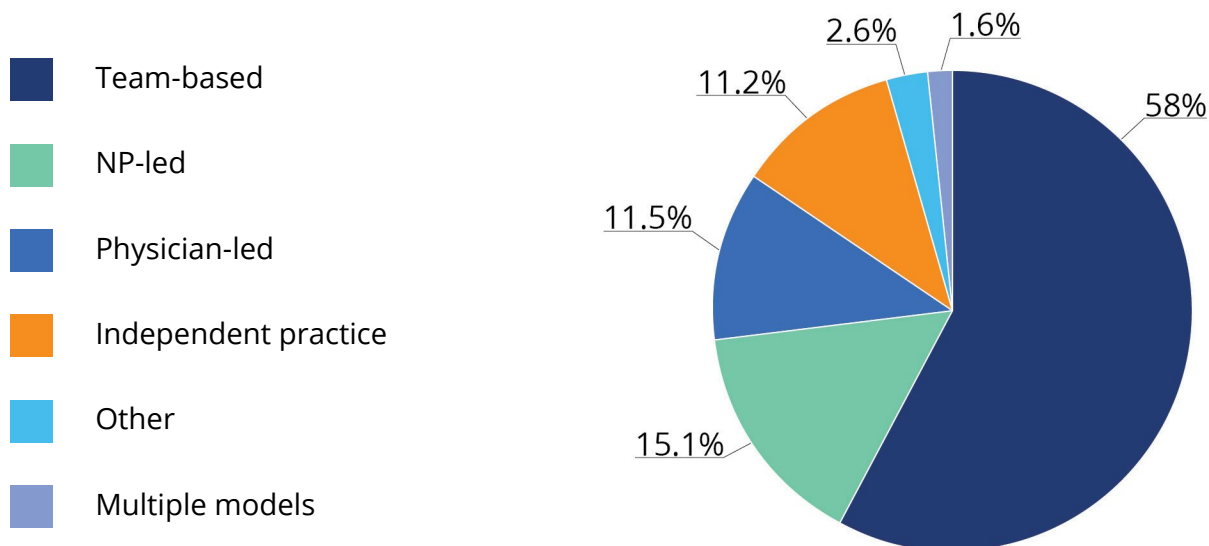


Figure 9. Providing virtual care (n = 1,289)



Characteristics of current NP practice

Figure 10. Model of care (n = 1,289)



Characteristics of NP practice

Patient populations and practice settings

The majority of NPs cared for patients of all ages (56%) or adult and older adult populations (36%) (Figure 6). More than half of currently employed NPs worked in primary health care (65%), followed by hospital (26%), residential care (5%) and other settings (4%). In addition to primary health care/family care and community clinics, NPs worked in varied community settings such as physician offices, mental health clinics, urgent care, home care, public health and correctional facilities. Hospital-based NPs practiced in a variety of inpatient, outpatient and emergency care settings. For residential care, NPs most commonly worked in long-term care (68%), followed by assisted living (18%), nursing homes (9%) and hospice facilities (6%).

Workload and care delivery

Over one-third of NPs (36%) managed a defined patient panel, with an average of 514 patients (Figure 7). A patient panel refers to a list of individuals whom an NP is responsible for providing care to. The number of patients NPs saw on a daily basis

varied widely (range 1-80), but on average it was 12 patients per day. Most NPs (56%) described their workload as manageable or very manageable, while 40% rated it as somewhat manageable and 4% as not at all manageable. Most commonly, NPs worked in team-based models of care (58%) in addition to NP-led (15%), physician-led (12%) or independent practice (11%), or other models (4%). The majority of NPs (73%) provided virtual care, accounting for about 16% of work time.

Employment conditions and compensation

Most NPs were employed in full-time (76%) positions, compared to part-time (16%), contract (5%), casual (3%) or job-share (0.5%) positions ([Figure 2](#)). NP positions were predominantly funded by provincial/territorial governments (51%), followed by regional health authorities (17%), publicly funded facilities (13%) and the federal government (4%) ([Appendix](#)). NP positions were also funded through other varied sources such as private for-profit companies, non-profit agencies, fee-for-service models and physicians.

NPs reported an average of 4.4 hours of overtime per week. When applicable, only 41% of NPs were compensated for overtime, and 39% were compensated for on-call duties. Participants reported mean annual paid leave of 19 vacation days, 2 paid personal days, 3 paid educational days, and highly variable sick time allotments. Educational expenses were reimbursed fully for 26%, partially for 43%, and not at all for 30% of NPs.

Comparison of participants to the 2018 survey

The current study had a greater number of participants (1,363 vs. 1,160) and more similar response rates (13-18%) across most provinces, compared to the previous study (15-50%) (Little & Reichert, 2018). However, the previous study had a higher overall response rate (22% vs. 14%). Provincial representation was similar for both studies, with the highest participation by NPs in Ontario, followed by Alberta, British Columbia and Quebec. The NPs in this study were similar to those from 2018 related to gender, including a predominantly female workforce (92% vs. 94%), but had a broader range of ages (27-74 years vs. 30-59 years). The proportion of bilingual NPs who could provide services in French and English was similar in both studies (19% vs. 18%). The 2018 report did not include information about NP characteristics related to ethnicity, education, licensure, professional roles or work experience, limiting further comparisons with the more detailed profile captured in this study.

NP job satisfaction

Overall job satisfaction

Job satisfaction was measured using the Misener NP Job Satisfaction Scale (Misener & Cox, 2001). The 44-item 6-point Likert scale assess job satisfaction as follows: 1 = very dissatisfied, 2 = dissatisfied, 3 = minimally dissatisfied, 4 = minimally satisfied, 5 = satisfied, and 6 = very satisfied. Overall, NPs were minimally satisfied with their jobs (total mean score = 4.2 [SD = 0.8]). This finding was consistent across most provinces and territories, unionized and non-unionized NPs, practice settings, and novice and experienced NPs. However, NPs in New Brunswick and Newfoundland and Labrador reported being minimally dissatisfied with their job (total mean scores 3.9 [SD = 0.4] and 3.7 [SD = 0.7] respectively). NPs who were thinking about leaving or actively planning to leave their current NP position were also minimally dissatisfied (total mean score 3.66 [SD = 0.72] – 3.8 [SD = 0.65]).

Areas of job satisfaction

The majority of NPs indicated they were satisfied or very satisfied (total mean scores ≥ 5.0) with only three areas of their jobs (out of 44 items, [Table 4](#)) related to:

- Percentage of time spent providing direct patient care (85%)
- Time allocated to see patients (85%)
- Level of autonomy (86%)

For most areas (33 out of 44 items, [Table 4](#)), NPs were minimally satisfied (total mean scores 4.0 – 4.9). The top six most frequently reported items which NPs were minimally satisfied with on their jobs related to:

- Reward distribution (29%)
- Opportunity to develop and implement ideas (24%)
- Input into organizational policy (24%)
- Acceptance and attitudes of physicians outside of their practice (24%)
- Opportunities for professional growth (23%)
- Processes used for conflict resolution (23%)

Table 4: Misener nurse practitioner job satisfaction scale

Item (n = 1,183)	Mean (SD)	Item (n = 1,183)	Mean (SD)
Vacation/leave policy	4.5 (1.4)	Interaction with other NPs, including faculty	4.2 (1.4)
Benefit package	4.1 (1.5)	Consideration given to opinions and suggestions for change in the work setting or office practice	4.0 (1.5)
Retirement plan	4.4 (1.5)	Input into organizational policy	3.6 (1.5)
Time allotted for answering messages	4.3 (1.3)	Freedom to question decisions and practices	4.0 (1.5)
Time allotted for review of lab and other test results	4.4 (1.3)	Expanding skill level/ procedures within scope of practice	4.4 (1.3)
Immediate supervisor	4.6 (1.4)	Ability to deliver quality care	4.9 (1.0)
Percentage of time spent in direct patient care	5.0 (0.9)	Opportunities to expand scope of practice and time to seek advanced education	4.0 (1.5)
Time allocation for seeing patient(s)	5.0 (0.9)	Recognition of work from supervisors	4.1 (1.5)
Amount of administrative support	4.1 (1.5)	Recognition of work from peers	4.7 (1.2)
Quality of assistive personnel	4.3 (1.4)	Level of autonomy	5.1 (1.0)
Patient-scheduling policies and practices	4.4 (1.2)	Evaluation process and policy	4.1 (1.4)
Patient mix	4.9 (0.9)	Reward distributions	3.5 (1.5)
Sense of accomplishment	4.6 (1.1)	Sense of value for what they do	4.4 (1.4)
Social contact at work	4.6 (1.2)	Challenge in work	4.9 (1.0)
Status in community	4.7 (1.1)	Opportunity to develop and implement ideas	4.2 (1.4)

Table 4: Misener nurse practitioner job satisfaction scale

Item (n = 1,183)	Mean (SD)	Item (n = 1,183)	Mean (SD)
Social contact with colleagues after work	4.5 (1.1)	Process used in conflict resolution	4.1 (1.4)
Professional interaction with other disciplines	4.6 (1.1)	Amount of consideration given to personal needs	4.2 (1.4)
Support for continuing education (time and money)	3.6 (1.6)	Flexibility in practice protection	4.4 (1.3)
Opportunity for professional growth	3.8 (1.5)	Monetary bonuses that are available in addition to salary	2.3 (1.5)
Time off to serve on professional committees	3.6 (1.4)	Opportunity to receive compensation for services performed outside of normal duties	2.5 (1.5)
Amount of involvement in research	3.4 (1.5)	Respect for opinions	4.3 (1.4)
Opportunity to expand scope of practice	4.1 (1.9)	Acceptance and attitudes of physicians outside of practice	4.3 (1.3)
Total and subscale scores (n = 1,183)		Total	Mean (SD)
Total score (out of 264)		186.1	4.2 (0.8)
Subscale 1: Intrapractice partnership/collegiality (out of 84)		53.7	3.8 (1.1)
Subscale 2: Challenge/autonomy (out of 60)		46.8	4.7 (0.8)
Subscale 3: Professional, social and community interaction (out of 48)		36.0	4.5 (0.8)
Subscale 4: Professional growth (out of 30)		18.5	3.7 (1.3)
Subscale 5: Time (out of 24)		18.1	4.5 (1.0)
Subscale 6: Benefits (out of 18)		12.9	4.3 (1.2)

Misener & Cox (2001)

These survey findings are consistent with the interview data indicating that for NPs, the most personally rewarding and satisfying aspects of their job relate to providing patient care and role autonomy. Relevant to both of these two motivating or intrinsic factors is the positive impact NPs have on patients and families.

Aspects of the role that provide me with satisfaction are the patients I am helping... the feedback I am getting from my patients... feeling like I have made a difference in their care and health outcomes... it is rewarding in that sense... it feels very good to be able to help. (NP5)

The relational aspect of caregiving also contributes to NP job satisfaction. For some NPs, the rewards associated with establishing meaningful relationships with patients and families helped to offset other challenging aspects of their jobs.

I love the relationship. I love that I know she's got four grandkids... we've got this connection... It helps me to understand what's important to her... I have really found so much value and reward in getting to know my patients and seeing things get better for them... Fills my bucket. (NP44)

NPs emphasized the importance of role autonomy for their job satisfaction. Role autonomy was promoted by working to their full scope of practice and through flexible work arrangements that enabled NPs to control their clinical work, schedule and the quality of care they provide.

The independence to deliver care that I believe is of high quality, autonomous and within my full scope is what gives me the greatest satisfaction in my job. (NP19)

Areas of dissatisfaction

NPs identified eight areas (out of 44 items) where they were dissatisfied or very dissatisfied (total mean scores ≤ 3.9) with their jobs ([Table 4](#)). The most frequent areas of job dissatisfaction reported by 40% or more of NPs related to:

- Reward distribution (41%), including compensation for services provided outside of normal duties (72%) such as overtime hours, and availability of monetary bonuses in addition to their salary (75%)
- Non-clinical contributions such as having input into organizational policies (41%) and time off to serve on professional committees (42%)
- Scholarly activities related to the amount of involvement in research (46%)
- Support (time and money) for continuing education (41%)

At least 30% of the NPs were also dissatisfied or very dissatisfied with these aspects of their jobs:

- Opportunities for professional growth (35%)
- Opportunities to expand their scope of practice (30%)
- Opportunities to expand their scope of practice and time to seek advanced education (31%)
- Consideration of their opinions and suggestions for change within the work setting or organization (30%)

Similarly, the interview data reinforced compensation as a primary source of NP job dissatisfaction. In particular, NPs felt that their current compensation did not adequately reflect their scope of practice, level of responsibilities and contributions to the health care system. Pay disparity in relation to physician compensation was also an issue.

I can understand a physician's perspective – you've done more training, and if you are doing certain skills outside of my scope of practice, you should get paid more for that. But if you have a patient who comes to a physician or an NP for strep throat, and you both do a rapid strep test and treat with amoxicillin... I don't understand why there's a pay disparity for doing the exact same thing to come to the same conclusion and to get the same outcome. (NP25)

In addition, when NPs lacked flexible work arrangements and control over their work or had restrictions on their autonomy and scope of practice – these factors were primary sources of job dissatisfaction.

There were control issues with the managers in my last work environment... just disrespectful. They were not even health care providers but were telling me how to do my job. (NP7)

Job satisfaction was also negatively affected when NPs were not able to meet their personal expectations to deliver timely high-quality care. Contributing factors included instances when workloads were unmanageable, patient waiting times were long, NPs lacked the expertise patients required, and when referral to specialists was delayed or not accessible, especially in rural communities.[AH3.1][OG3.2][AH3.3]

I would say, workload can sometimes play into it... you're just trying to see as many people as you can because you are really concerned for these people... this can create some dissatisfaction... (NP9)

Comparison of current and previous job satisfaction results

Direct comparison of overall job satisfaction between the current results and those from the previous CFNU survey (Little & Reichert, 2018) is not possible due to differences in how job satisfaction was measured. However, the previous results indicate that 80% of NPs were satisfied with their jobs, whereas the recent results indicate that the majority of NPs are minimally satisfied.

As in the previous 2018 survey, factors related to patient care and time to provide patient care were the top two sources of job satisfaction, and salary/benefits was the leading source of job dissatisfaction. Satisfaction with patient mix was similar in 2018 to the current study (88% vs. 82%). In this recent study, fewer NPs were dissatisfied with opportunities for professional development (35% vs. 47%) and input on organizational policies (41% vs. 49%).

NP recruitment and retention

About 37% of NPs were thinking about leaving their current position or actively planning to leave their current position ([Table 5](#)). The main factors contributing to intention to leave were:

- inadequate salary/compensation/benefits (62%),
- stress/burnout (42%), and
- workload (27%).

Nearly 40% of NPs changed positions in the past three years (38%). The top three reasons given for leaving their previous position included:

- stress/burnout (34%),
- workload (26%), and
- inadequate compensation (22%).

Table 5: Recruitment and retention

Changed positions in past 3 years (n = 1,243)	n	%
Yes	472	38.0
No	771	62.0
Previous position NP (n = 471)	n	%
Yes	411	87.3
No	60	12.7
Main reasons for leaving previous NP position* (n = 411)	n	%
Career advancement	78	19.0
Personal reasons	110	26.8
Inadequate salary/compensation	91	22.1
Workload	107	26.0
Stress/burnout	142	34.6
Lack of professional autonomy	68	16.6
Other	279	67.9
Main factors considered when seeking current position* (n = 1,243)	n	%
Salary/compensation	582	46.8
Benefits	209	16.8
Workload	301	24.2
Hours of work	447	36.0
Geographic location	420	33.8
Patient population	268	21.6
Practice setting	433	34.8

* Participants were able to select more than one response

Table 5: Recruitment and retention

Role autonomy	448	36.0
Scope of practice	226	18.2
Other	148	11.9
Plans for employment next year (n = 1,183)	n	%
No immediate plans to leave NP position	751	63.5
Thinking about leaving NP position	313	26.5
Actively planning to leave NP position	119	10.1
Main reason considering leaving NP position (n = 432)	n	%
Retirement	60	13.9
To work in a non-NP role	37	8.6
Career advancement	77	17.8
Personal reasons	97	22.5
Inadequate salary/ compensation/benefit	267	61.8
Workload	168	38.9
Stress/burnout	181	41.9
Lack of professional autonomy	100	23.1
Other	43	9.42
Lack of support from management/ leadership/physicians	27	5.7
Interpersonal/interprofessional issues	16	3.4

During the interviews, NPs provided further insight about factors that influenced their decisions to stay or leave their current position. Among the commonly reported reasons to leave their NP position were inadequate staffing and concerns about providing safe care, poor compensation and inadequate benefits such as vacation time and maternity leave, and poor work flexibility. As one NP explained:

I left full-time in the first place, because we were grossly understaffed... if it doesn't feel safe, I'm not staying. But if you staff it well, I'll probably never leave. (NP34)

Reasons for NPs to stay in their positions included a healthy work environment, work flexibility and appropriate remuneration. As illustrated in this quote, healthy work environments that provide work-life balance are highly valued by NPs:

And the reason why I'm still in my role, and why most NPs are still in their role at my health center, and why we are growing the health center, is the push on work-life balance... the majority of us left the nursing profession for continuing education, but also because nursing shifts are just not something that worked when it comes to having a family. So, having flexibility is important for many people. (NP26)

The discussion regarding retention also centred on new graduate NPs. Interview participants suggested that new graduate NPs may be struggling with transition to practice due to inadequate educational preparation and limited tailored mentorship opportunities.

...you're just flying by the seat of your pants, so since the education wasn't as strong, I was able to balance it out with more time in between patients or after, or to do my research to really look things up. (NP25)

In addition, the lack of education to prepare NP graduates for speciality practice was also identified as an issue affecting recruitment and retention.

...how do you graduate and then go straight into being a nephrologist NP? Where does all your other primary care stuff go? What if you ever want to switch back into primary care? Like, you're basically screwed. So, if you go into things like eating disorders or mental health, it's just so specialized. (NP21)

The lack of transition supports that recognize new graduates as novice NPs can also impact their retention in the workforce.

...the challenge with being a new grad NP is that you may well have been a very high-level expert nurse, but you are sort of starting back in this novice position with different skills that need to be grown... So, I think recognizing that there is a difference between a new grad NP versus one with 3 years versus one with 6 years, and providing adequate support for that transition, so that the NPs can feel supported as they grow, would be really important. (NP19)

Interview participants identified a variety of other strategies and supports that facilitate new graduate NP transition to the workplace. These strategies emphasized the importance of support from the interprofessional health care team, as well as support from other NPs, including social support from NP peers.

I know whenever we've had new NPs coming into our little clinic, the more experienced NPs always reach out. We're always like we have a WhatsApp chat group with previous NPs that have worked at our clinics. It's literally called NP Survivor Group, and if you have any questions – just shoot it out on WhatsApp. No matter where we are, we will try and answer. So, it's just about providing support to each other and creating a community of support... (NP21)

NPs also recommended more formal transition support:

When I finished my registered nursing, there was a new grad initiative. Where there's that, you were able to do, like, eleven weeks, I believe, like, extended orientation with a colleague, and I felt that that was a great experience when I was transitioning from student to registered nurse and I think something like that would be great for nurse practitioners. (NP42)

Retention issues for participants not currently working as NPs

From the survey, 20 participants (1.5% of the sample) were not currently employed as NPs. Previously they had all been working in clinically focused roles and mostly in full-time publicly funded positions in primary health care ([Table 6](#)). Their reasons for no longer working as NPs included:

- inadequate salary/compensation/benefits (95%),
- stress/burnout (35%) and
- health/personal reasons (35%).

Table 6: NPs not currently working (n = 20)

Most recent NP position	n	%
NP in clinical practice	20	100.0
Type of setting	n	%
Hospital	3	15.0
Residential care	1	5.0
Primary care	13	65.0
Other	3	15.0
Unionized/non-unionized	n	%
Unionized	9	45.0
Non-unionized	11	55.0
Type of NP position	n	%
Full-time	11	55.0
Part-time	8	40.0
Casual	1	5.0
NP position funding source	n	%
Provincial/territorial government	9	45.0
Federal government	1	5.0
Regional health authority or local health integration network	3	15.0
Publicly funded individual facility	4	20.0
Physician funding	1	5.0
Other	2	10.0
Main reasons not currently working as an NP	n	%
Retired	2	10.0
Leave of absence	4	20.0

Table 6: NPs not currently working (n = 20)

Main reasons not currently working as an NP (Cont.)	n	%
Terminated	3	15.0
Working in a non-NP role	2	10.0
Health/personal reasons	7	35.0
Inadequate salary/compensation/benefits	20	95.0
Workload	3	15.0
Stress/burnout	7	35.0
Lack of professional autonomy	3	30.0
Unable to find suitable NP position	2	10.0
Other	1	5.0
Planning to return to work as an NP	n	%
Yes	13	65.0
No	7	35.0
Main factors considered when selecting employment as an NP (n = 13)	n	%
Salary/compensation	7	53.9
Benefits	2	15.4
Workload	7	53.9
Hours of work	7	53.9
Geographic location	2	15.4
Patient population	2	15.4
Practice setting	6	46.2
Role autonomy	2	15.4
Other	2	15.4

Workload, lack of professional autonomy and inability to practice to full scope were additional frequently reported factors that contributed to NPs leaving their position.

Despite these challenges, 65% of participants planned to return to NP practice. Among those intending to return, the most influential employment considerations included:

- salary/compensation (54%),
- workload (54%),
- hours of work (54%) and
- practice setting (46%).

NPs represented by unions

Among the surveyed NPs, 54% (n = 694) reported being in unionized positions, which is comparable with findings from the previous CFNU study (Little & Reichert, 2018). Overall, 79% (n = 548) of NPs reported they were knowledgeable (very or somewhat) in their collective agreement. However, the majority of NPs (75%, n = 522) did not feel that their union represents issues that are of concern to NPs. From the narrative survey data, four frequently reported themes about factors that contributed to NPs' perceptions about inadequate union representation were identified:

- Dominance and focus on other groups
- Lack of understanding and recognition of the NP role
- Compensation and collective agreement inadequacies
- Alternative representation models

Collective bargaining processes for all unionized employees (including NPs in some jurisdictions) are governed by union constitutions and by-laws as well as provincial and territorial legislation. Within these processes, concerted efforts are being made by all parties to promote the unique needs of nurse practitioners.

Themes for improving NP recruitment and retention

Funding and remuneration

Similar to the previous CFNU NP report (Little & Reichert, 2018), funding and in particular remuneration continued to be a key theme affecting NP retention.

Remuneration

NPs continue to be paid below market value for their contribution to the health care system (Splane et al., 2023; Marceau et al., 2021), and remuneration tends to be inconsistent across the country (El Hussein & Ha, 2022; Martin-Misener et al., 2015). Of NPs (76%) surveyed who worked full time, 80% reported their income between \$100,000 to \$149,999, 3% were less than \$100,000, and 16% more than \$150,000. See [Table 7](#) for a summary of income of all NPs surveyed. Despite adjustments over time, some salaries still fall short of the Hay Group Healthcare Consulting (2013) recommendation of \$103,000–\$135,000 for a full-time NP, which corresponds to \$136,000–\$178,000 in 2025 dollars based on Canadian Consumer Price Index inflation (Statistics Canada, 2025a).

	Full-time (n = 943)		Part-time (n = 198)		Job share (n = 7)		Casual (n = 31)		Contract (n = 64)	
	n	%	n	%	n	%	n	%	n	%
Current/most recent annual salary as an NP										
< \$74,999	3	0.3	27	13.6	0	0.00	12	38.7	10	15.6
\$75,000 - 99,999	28	3.0	47	23.8	0	0.00	3	9.7	3	4.7
\$100,000 - 124,000	330	35.0	64	32.3	3	42.8	2	6.5	18	28.1
\$125,000 - 149,999	420	44.5	32	16.2	2	28.6	8	25.8	14	21.9
\$150,000+	148	15.7	25	12.6	0	0.00	5	16.1	17	26.6
Prefer not to answer	14	1.5	3	1.5	2	28.6	1	3.2	2	3.1

Hagan and Curtis (2018) indicated that the most influential determinant to leaving an NP position was remuneration. Similarly, Fournier et al. (2022) found that the main factor for primary health care NPs to leave their position was remuneration. Among the 37% of participants who reported considering or actively planning to leave their NP position, over 60% identified insufficient compensation and benefits as the primary contributing factor (Table 6). Related to NPs (n = 472) who had left a previous position in the last 3 years, 47% indicated they sought out their current position due to salary, and 22% left their previous position due to inadequate compensation. Of those surveyed not currently working as an NP (n = 20), more than half (54%) indicated one of the top factors for considering future employment was salary and compensation (Table 7).

Lack of adequate remuneration as a retention strategy was also shared by multiple interview participants.

■ *So, for those aren't working to stay like better compensation, so like more compensation. (NP5)*

■ *Well, I think remuneration is a big part, for sure. (NP21)*

■ *Yeah, so...to improve NP retention, it would be the salary. Honestly, I think that's the same issue with everybody across the board right now. (NP26)*

■ *Another reason why I haven't chosen to work in a community health or family practice, they're often paid a lot less. And I know it's not always about the money, but after all the time and effort you want to be compensated appropriately, and I wouldn't want to be making what I would be making as an RN. I do feel we deserve more, so wages are a huge one. (NP12)*

As outlined in the previous CFNU study (Little & Reichert, 2018), remuneration for NPs often reflects the pay scale of registered nurses rather than physician compensation. Despite the closer similarities to role and scope of a physician, NPs remain in comparison to RN pay scales, sometimes overlapping their scale, which can undervalue the role of the NP.

This was shared by interview participants:

■ *I think the salary needs to be changed, and, like, we're not being paid, like, market value for the risk and. Sorry, [at the] end of the day. Just, it doesn't, it doesn't fit, like, how much work that we're doing. We're not being compensated appropriately, so I think that's one of the bigger reasons why retention is an issue. (NP42)*

I've seen letters from NPs, where an NP has expressed some concern about remuneration, and their response was: well, doctors go to school longer. And I'm like: it's just such a short-sighted answer. (NP21)

I also know just wage and vacation time, a very close NP friend of mine threatened to quit twice. She handed in her resignation twice in order to get raises to be appropriate for what she should be making. She was making more as an RN, and she had to go to them and say, look, I can't keep doing this... And then when all the RNs got a raise with their contract, she had sent another letter to be on par again, so that's a story I hear a lot. (NP 12)

We are being paid better than the RNs, but we're a huge distance away from what doctors are being paid... I would like to see pay more reflective of the work that I do. (NP1)

Lack of appropriate compensation was also reported by the 75% of participants, who were minimally dissatisfied, dissatisfied or very dissatisfied with monetary bonuses that are available in addition to their salary. The majority (72%) were also minimally dissatisfied, dissatisfied or very dissatisfied with an opportunity to receive compensation for services performed outside of their normal duties.

Survey participants indicated that adequate compensation encompassed not only base salary but also remuneration for overtime and on-call duties. Of those surveyed, where overtime payment was applicable (n = 1013), more than half (59%) are not compensated for overtime. On average the NPs reported working 4.4 hours of overtime hours per week. For NPs (n = 524) where on-call payment was applicable, more than half (61%) were not compensated for on-call work.

Despite the recommendations made by Little and Reichert (2018), inadequate and inconsistent remuneration remains a critical challenge for NPs across Canada. Current salaries often fall below inflation-adjusted benchmarks and fail to reflect the complexity and scope of NP practice. Evidence from both survey and interview data indicates that compensation is a primary determinant of retention and career decisions, with many NPs considering leaving their roles due to insufficient pay. Without addressing these disparities through standardized and competitive funding models, health systems risk exacerbating workforce instability and limiting the advancement of the NP role, ultimately impacting access to health care for Canadians.

Funding

Funding for NP positions has remained largely unchanged since 2018 (Little & Reichert, 2018), and funding models continue to vary across Canada, with the majority working in salaried positions through health authorities or organizations (Splane et al., 2023; Black et al., 2020).

Survey participants reported their top three funding models as follows ([Appendix](#)):

- Provincial or territorial government (51%)
- Regional health authority local health integration network (17%)
- Publicly funded individual facility (13%)

As mentioned by Little and Reichert (2018), government funding models like those described above depend on securing new money or reallocating money from existing budgets to employ more NPs. This is a stark difference from physician funding, which is separate from other health services. This type of health funding creates a deterrent to hiring NPs as their funding comes from the global health or hospital budget, whereas physician income does not (Bryant-Lukosius et al., 2026).

However, the landscape may be changing across the country. As previously mentioned, British Columbia, Saskatchewan and Alberta have implemented direct government-contracted funding models for primary health care services. With the forthcoming interpretation changes to the *Canada Health Act* effective April 1, 2026 (Health Canada, 2025a), Newfoundland and Labrador (Government of Newfoundland and Labrador, 2025) have announced plans to adopt a similar model, and additional provinces may follow as the implementation date approaches. While future funding models may be upon us in response to the *Canada Health Act* interpretation letter, these models are new and have not been evaluated for NP job satisfaction. Black et al. (2020) indicated that the lack of appropriate funding for NPs in the Canadian health care system can impact role advancement of NPs across the health system.

This study highlighted that approximately 6% of NPs work in private for-profit practice or are self employed through patient-paid fee-for-service ([Appendix](#)). Canadian Institute for Health Information (2025) reports that from 2023 to 2024, the highest increase in NPs in direct care were for private nursing agencies and self employment, a 12% increase. This is a new emerging phenomenon amongst NPs and is an opportunity for future research.

Despite the recommendations made by Little and Reichert (2018) and irrespective of the chosen funding approach, insufficient funding creates disparities in NP role allocation across the country and impedes role advancement, ultimately affecting health care access to Canadians.

Role clarity and scope of practice

In 2025 fewer NPs reported not working to their full scope of practice than in 2018 (Little & Reichert, 2018). In 2018, 26% of NPs reported not working to their full scope of practice, whereas in 2025 NPs reported being somewhat satisfied with the opportunity to expand their scope of practice (mean of 4.1, SD = 1.5) and with expanding skill level/procedures with their scope of practice (mean of 4.4, SD = 1.3). When asked to identify main reasons for not currently working as an NP, only three 2025 participants were unable to practice to full scope.

Approximately half (51%) of the participants indicated they were satisfied or very satisfied with their opportunity to expand their scope of practice. The remainder were either minimally satisfied (30%) or dissatisfied (20%). There was a slightly higher proportion of respondents who reported being satisfied with expanding skill level/procedures within their scope of practice (58%). Respondents to the question about opportunities to expand their scope of practice and time to seek advanced education had a lower proportion who were satisfied (48%) and higher proportion who were dissatisfied (31%).

Analysis by province/territory

The Misener NP Job Satisfaction Scale (Misener & Cox, 2001) includes six subscales ([Table 4](#)). The one being closest to role clarity and scope of practice is subscale 2, which is entitled Challenge and Autonomy. In all provinces/territories, total mean subscale scores ranged from 4.51 (SD = 0.3) to 4.89 (SD = 0.7.), indicating that NPs were minimally satisfied with this aspect of their jobs. The provinces with the top three highest scores were Alberta, Manitoba and Quebec. Those with the lowest scores were Newfoundland and Labrador, New Brunswick and Prince Edward Island.

Qualitative comments indicated that NPs' scope of practice was broad with few restrictions. The following quote illustrates how one NP described the relationship of scope of practice to autonomy.

So, autonomy, I think of it as the ability to work within my scope without having somebody overseeing what I'm doing. So, for lack of a better word, they leave me alone. They let me just do my job, because that's what I'm there to do. And that's how I would define it. I think simply. It's just like, they let me do what my job is supposed to be doing... I work to my full scope of practice, which equals autonomy. (NP21)

This improvement aligns with the significant changes that have occurred in national and provincial legislation and various policies to reduce barriers to scope of practice. In 2018, “remove legislative barriers to working to full scope of practice” was the second in the top five factors identified as being most important to improving NP retention and recruitment. In the current study, when asked about main reasons for leaving their previous position, only 12% (n = 49) of participants identified being unable to practice to full scope. Of the 20 participants who indicated they were not currently working in clinical practice in an NP role, three indicated a main reason for this was being unable to practice to full scope, and three indicated a lack of professional autonomy.

For 18% (n = 226) of NP participants, scope of practice was a main factor of consideration when seeking employment for their current position. However, only two unemployed respondents selected role autonomy, and none selected scope of practice as a main factor of consideration when selecting future employment as an NP.

Data from CIHI in 2024 indicated that the legal scope of practice for NPs is unrestricted in all provinces and territories for the following services: independently autonomously care for patients; comprehensive advanced health assessment and diagnosis; order and interpret diagnostic tests; prescribe medication; prescribe controlled drugs; prescribe medical marijuana; prescribe medical supplies/devices; refer to other health professionals; medical assistance in dying; biopsy, mole removal; cast, suture; and complete driver's health exam (CIHI, 2024a).

However, CIHI data also report that scope of practice for NPs is restricted or partially restricted for involuntary mental health certificate in 10 provinces and territories, hospital admit/discharge are restricted or partially restricted in six provinces and territories, long-term care admit is restricted in six provinces and territories, and completion of disability forms in one province. These restrictions may contribute to explaining dissatisfaction with scope of practice among NPs in our sample. It is also possible that NPs were dissatisfied with limitations on scope of practice at an organizational level. As the above quote illustrates, scope of practice and autonomy are interconnected, and autonomy is often influenced by organizational factors (CIHI, 2024a).

Burnout

Burnout is the result of chronic work-related stress and is associated with feelings of exhaustion, negative feelings about or distancing from one's job, and reduced work effectiveness (World Health Organization, 2019). Excessive workload and stressors associated with lack of role autonomy and role clarity and job pressures may contribute to NP burnout (de Lisser et al., 2024). Similarly, aspects of burnout such as excessive workload are also associated with poor job satisfaction (Fournier et al., 2019), and burnout and poor job satisfaction contribute to turnover (Tamata & Mohammadnezhad, 2022).

Likewise, in this study, workload and stress/burnout were reported by 26% and 35% of NPs respectively as reasons for leaving their last NP position (Table 6). These findings are similar to a national membership survey of predominantly registered nurses, in which 31% screened positive for burnout (CFNU, 2025). NPs who were considering leaving their current NP position within the next three years also cited workload (27%) and burnout (42%) as the main reasons. For NPs who were not currently working as an NP, stress/burnout (35%) was the second most common reason (after inadequate benefits) for being unemployed, along with personal reasons or health (35%) and workload (15%).

When considering factors that influenced their recruitment or decision to accept their current position, workload was also reported by 24% of NPs (Table 5). Workload was also reported by 54% of NPs who were not currently working as a primary consideration when selecting a new position (Table 6).

NP insights on burnout were further explained from the interview data, in which having an unmanageable workload was a prominent feature. Workload demands were often driven by organization and system needs, as well as a NP's own concerns and commitment to meeting patient health needs. Unmanageable workloads were compounded by the complexity of patient care needs.

NPs also described how insufficient time off to recover from work or the inability to distance themselves from work during time off were factors that led to burnout and negatively impacted their physical and mental health.

I was going hard with the burnout, and that kind of impacted my health. I was like I can't do this, and I really crashed and burned. So, I find that working 3 days a week is a good balance for me, because it allows me to have a little bit more breaks in my week to recover mentally from some of the challenging situations. (NP21)

Some NPs were still angry recovering from their experiences in working during the COVID-19 pandemic, and this influenced their decisions to avoid burnout by working in environments that valued their contributions, and that promoted their health and quality of life by offering a work-life balance.

And frankly, after a lot of the crap we went through with COVID... I'm not gonna burn myself to the bone for a system that is not interested in valuing my skills or experience. I tried. And I have never called as many code whites in my entire life as I did in those two years... during COVID. (NP33)

The significance of burnout

The issue of burnout was not identified in the previous CFNU NP study (Little & Reichert, 2018) that occurred prior to the COVID-19 pandemic. The current study results indicate that burnout is an important issue affecting the recruitment and retention of NPs and their overall health and well-being. These findings are consistent with two Canadian studies. Harwood et al. (2024) found that during the pandemic, 81% of acute care NPs (n = 42) from one Ontario hospital system had high to moderate levels of burnout and minimal job satisfaction. Post-pandemic, a national study of 229 NPs found that at least 33% had high levels of burnout (Heale, 2025b) and were more likely to leave their position and the profession. Like the current study results, factors contributing to NP burnout related to role clarity and feeling undervalued, unmanageable workloads and patient complexity, lack of professional autonomy, and organization and system pressures such as inadequate workplace resources and compensation, and working beyond their scope of practice (Heale, 2025a).

Sense of accomplishment and professional development

A sense of personal accomplishment from work has been linked to concepts like well-being and resilience in the literature focused on advanced practice nurses (APNs), including NPs (Dyrbye et al., 2021; Hsu et al., 2024). This may serve as a protective factor from burnout, as a sense of accomplishment is linked to job satisfaction for APNs (Han et al., 2018).

In this study, 26% of survey participants reported feeling very satisfied with their sense of accomplishment and 50% reported feeling satisfied with their sense of accomplishment. The interview data sheds light on these issues, as participants described feeling a sense of accomplishment from making a difference in the lives of their patients.

... aspects of the role that provide me with satisfaction would be the patients you're helping... the feedback you're getting from your patients... I really appreciate this, or I really feel like you made a difference in their care... just seeing the difference you make in their health outcomes... is rewarding in that sense... it just feels very good to be able to help. (NP5)

Yeah, just patients... I'm a clinician at heart... I see value in research, I see value in educating. But nothing kind of fills my bucket like a patient who we figure out a solution for something that's been bothering them for years, or improve their quality of life despite... that's what is the most rewarding part of my job, is just really walking with people... (NP44)

Study participants also reported professional development as a retention factor. From the literature, professional development for APNs is important to keep their clinical knowledge current, share knowledge within the nursing profession and provide a sense of career progression (Wright et al., 2024). From the survey, most participants (62%) were not satisfied with the level of support from their employer for professional development, via funding and/or protected time. More specifically, respondents were either minimally satisfied (21%), minimally dissatisfied (11%), dissatisfied (14%) or very dissatisfied (16%).

Study participants highlighted the current importance of access to professional development, considering the high proportion of novice NPs, perceptions that current education is insufficient to prepare NPs for the complex realities of practice, coupled with heavy workloads. Participants provided specific examples of how employers can support access to professional development.

Leaders/administrators providing protected time:

For my own education, I can take education days. I just did a certificate of leadership, and my manager was very supportive of me taking days off. (NP29)

Providing access to funds for professional development:

They cover the cost to do our certified diabetes educator exam every five years. So, they support that cost and the time they allow one NP a year to use some educational funds. (NP7)

Providing access to team resources (e.g., clinical subscriptions):

They provide us with access to guidelines and resources that are paid, like UpToDate and RxFiles. Or they pay for licenses to those kinds of products that help support our practice. (NP5)

From the qualitative data, participants provided examples of support for professional development, which contrasts with the survey data, in which most respondents were less than satisfied with access to protected time and funds for professional development. This could be explained by the lack of formalized access to professional development, which may not be built into NP job contracts, leaving professional development access up to the discretion of the immediate supervisor/administrator. This lack of standardization in access may account for the variation in respondent/participant responses.

Interprofessional relationships and collaborative models of care

Although the survey did not include a stand-alone question specifically targeting interprofessional relationships and collaborative models of care, this theme emerged from several items of the Misener Job Satisfaction Scale (Misener & Cox, 2001) and from response options to questions on the main reasons for leaving a previous NP position, the main factors considered when seeking a current NP position and the main reasons for considering leaving a current NP position.

Overall, most respondents reported at least minimal satisfaction with interprofessional aspects of their work. Professional interaction with other disciplines was rated as minimally satisfied to very satisfied by 1,034 respondents (87%). Interaction with other NPs, including faculty, was rated as minimally satisfied to very satisfied by 880 respondents (74%). Recognition of their work from peers was also generally positive, with 1,025 respondents (87%) indicating minimal to high satisfaction. Acceptance and attitudes of physicians outside of the respondent's own practice were somewhat less positive but still favourable overall, with 938 respondents (79%) reporting minimal to high satisfaction.

When asked about the main reasons for leaving a previous NP position, interpersonal and interprofessional issues were explicitly identified by 29 participants (7%). In their qualitative comments, these respondents described toxic, disrespectful or bullying behaviours from physicians, managers and coworkers, including harassment, gas-lighting, lack of respect for the NP role and persistently toxic work cultures. They also reported dysfunctional team dynamics, such as interference with clinical autonomy,

unfair workload distribution, very poor collaboration with physicians and administration, anti-LGBTQ attitudes and incompatibility with specific colleagues as key factors contributing to their decision to leave.

In contrast, when participants were asked about the main factors considered when seeking their current NP position, workplace culture and model of care were identified by 59 participants (5%) as central to their decision-making. These respondents most often highlighted a positive team-based work culture with collaborative and respectful colleagues (including physicians), supportive managers and leadership, and strong practice support as primary reasons for choosing their current role. They also emphasized the importance of joining environments they already knew and trusted, where the NP role is respected, decision-making is shared, and the overall atmosphere is perceived as safe, welcoming and professionally satisfying.

An interview participant highlighted how supportive their collaborative environment was:

This is a medical home, so it's very collaborative. So, we have various professionals working together. There's more NPs here. There's a doctor here. So, there's just more people to collaborate with and to help out, especially being a newer graduate to have people to rely on, especially for complex cases and things you're not sure about. (NP5)

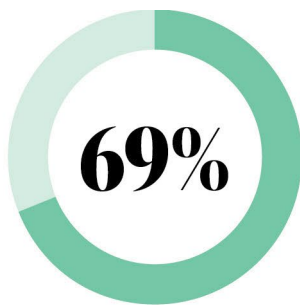
Finally, when participants were asked about the main reasons for considering leaving their current NP position, interpersonal and interprofessional issues again emerged as an important theme, identified by 16 participants (3%). These respondents described feeling disrespected, undervalued and unappreciated in their roles, particularly by leadership and physician colleagues, citing limited understanding of NP competencies, exclusion from decision-making processes and lack of support for professional development. Additional concerns included toxic or bullying management practices, oppressive or colonial organizational cultures, professional isolation, poor team dynamics and loss of autonomy over their practice, all of which contributed to their contemplation of leaving their current position.

Recommendations

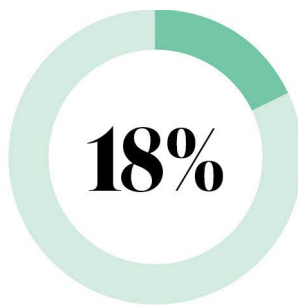
Recommendation 1: Creating positive work environments

Nationally and internationally, there is heightened recognition of the critical need to transform the environments in which NPs work, in order to improve recruitment and retention and the optimal implementation of their roles (Splane et al., 2023; Ziegler et al., 2021). Negative NP work environments are associated with feeling overwhelmed and work overload, burnout, poor job satisfaction and feeling devalued (Abraham et al., 2021; de Lisser et al., 2024; Fournier et al., 2024; Heale, 2025a).

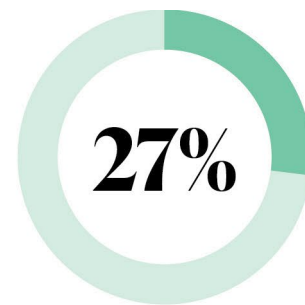
Promisingly, many workplace barriers to NP role implementation and job satisfaction are preventable and can be addressed through systematic and organization-wide strategies (Bryant-Lukosius & DiCenso, 2004; DiCenso et al., 2010). Thus, strengthening NP work environments is an essential pathway forward to improve NP role implementation, job satisfaction and retention. For example, in this study the greatest sources of NP job dissatisfaction involve policies and practices within work environments related to professional growth, continuing education, and opportunities to contribute to organizational improvement through input on policies, participation on committees and involvement in research. These issues are feasible to address, and if so, may significantly improve NP job satisfaction.



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NPs require reasonable role autonomy or control over their clinical work and workload to effectively meet patient needs.

While most NPs (69%) were satisfied with their supervisor, 18% were dissatisfied. In addition, 27% of NPs were dissatisfied with the recognition they received from their supervisor and the amount of administrative support. The NPs described that not all health care administrators and managers had a good understanding of their role. Decisions were also made about their work in order to meet organizational goals but often failed to include NP input in

the decision-making. Organizational policies and decisions that restrict NP scope of practice and role autonomy may contribute to burnout (O'Connor et al., 2023) and result in poor job satisfaction and retention (de Lisser et al., 2024). As advanced health care providers, NPs require reasonable role autonomy or control over their clinical work and workload to effectively meet patient needs and deliver high-quality accessible care within their scope of practice. Building meaningful relationships with patients and having a positive impact on patient health and quality of care is the primary source of NP job satisfaction. When NPs lack control over their clinical practice to meet their expectations for addressing patient needs and delivering quality care, it becomes a source of dissatisfaction and burnout (de Lisser et al., 2024; Fournier et al., 2019).

Importantly, NP burnout is also associated with poor quality of care (Abraham et al., 2021). In this study NPs identified burnout and poor work-life balance as major factors affecting their overall health, job satisfaction, retention and future employment decisions. Excessive workloads that did not consider the challenges of NP practice and the complexity of patient care contributed to burnout.

Research on NP recruitment and retention is evolving as is NP practice in Canada. As one example, independent NP models of practice (e.g., NP-led clinics, fee-for-service practices, NP panels, independent contracts, NP as most responsible provider) are emerging. Recent studies from the United States suggest that NPs with their own panel have increased workloads and as a result may be more likely to experience burnout (Kim et al., 2024). Further research is needed to evaluate emerging models of NP practice and their impact on NP workload, burnout, job satisfaction and retention.

Health Canada's (2024) *Nursing Retention Toolkit* offers strategies applicable to enhance the work environments of all nurses, but few are specific to NPs. Building on this toolkit, the CFNU offers the following recommendations that are tailored specifically to create positive work environments for NPs.

1. For unions

- Provide representation to address priority issues impacting NP practices and their work environment related to job satisfaction, health and well-being, recruitment and retention.

2. For NP employers


- Establish an organizational vision that recognizes NPs as advanced health care leaders and that maximizes the use of their clinical, education, research and scholarship expertise to meet improvement priorities.
- Provide standardized education and training about the NP role and optimal role implementation related to NP leadership, autonomy and scope of practice for organizational leaders and supervisors who make decisions about the hiring and supervision of NPs.
- Develop, review and strengthen organizational policies regarding the hiring and retention of NPs, that enable role autonomy and scope of practice and address manageable workloads, continuing education and professional growth.
- Offer flexible work conditions to promote work-life balance and to accommodate the personal and professional practice needs of individual NPs.
- Establish and/or enable NP participation in continuing education and other forums (e.g., communities of practice) that foster NP resilience and professional growth.

3. For provincial and national NP leaders

- Collaborate with health care leaders, employers and NP supervisors to develop, implement and evaluate an NP Retention Toolkit.
- Offer education initiatives to support NPs in developing skills to negotiate for and manage appropriate workloads and the stress associated with the challenges of NP practice.

4. For nurse scientists and NP researchers

- Conduct research to further examine the relationships between NP job satisfaction, burnout, workload, recruitment and retention.
- Evaluate the impact of funding models (fee-for-service, independent practice) and emerging models of NP practice (e.g., NP panels and panel size) on role autonomy, workload, burnout, retention and job satisfaction.



Recommendation 2: Remuneration and funding models

Nationally, NPs are working across an increasingly diverse range of practice environments, yet remuneration and funding models have not kept pace with the rapid evolution of NP roles and service delivery. Funding structures continue to vary substantially across jurisdictions and between public and private health care settings, with implications for NP role implementation, autonomy, job satisfaction and workload (Duff et al., 2022; Marceau et al., 2021). Despite previous recommendations calling for modernized NP funding mechanisms, there has been limited progress in developing equitable, transparent and NP-specific remuneration models (Little & Reichert, 2018; Marceau et al., 2021).

NPs in this study reported working in traditional publicly funded primary health care, community health centres, acute care, home and community care, and an expanding private sector that includes private practice, virtual care platforms and contract-based practice. Seventy-three percent of participants reported providing some form of virtual care within their practice. These rapidly emerging private-sector opportunities are advancing faster than policy frameworks can adapt, raising concerns about equity, sustainability and the potential for widening gaps in the publicly funded system.

A specific concern highlighted by participants is the misalignment between NP contributions and remuneration under physician-focused funding models. In jurisdictions using blended or capitation-based physician funding models, physicians can bill codes or receive roster-based payments for patients whose care is primarily provided by NPs. While patients remain formally attached to a physician's roster, NPs often assume responsibility for the majority of direct patient care, case management and clinical follow-up. This can obscure NP workload, limit recognition of NP contributions, and create barriers to equitable funding and workload allocation. These issues mirror longstanding concerns that restrictive or outdated funding structures diminish NP autonomy and limit optimal role utilization (Marceau et al., 2021).

Qualitative findings from this study further demonstrate that NPs with independent patient panels, now emerging in provinces such as British Columbia, Saskatchewan and Alberta, experience both increased autonomy and heightened workload pressures. NPs described the stress of being solely responsible for a panel, managing complex patients without adequate administrative or interprofessional support, and experiencing challenges balancing accessibility with personal well-being. Similar patterns have been observed in the United States, where primary care NPs with independent panels report greater workloads, longer work hours and higher rates of burnout, compared to NPs working without their own panels (Kim et al., 2024). These findings underscore the need for careful evaluation of emerging Canadian models to ensure they do not inadvertently contribute to NP burnout, role strain or poor retention.

If private NP practice grows in response to limited public sector flexibility, funding and infrastructure, the public system may face further strain and challenges in recruiting and retaining NPs.

The policy landscape surrounding NP remuneration is likely to continue shifting. New federal interpretation letters related to the *Canada Health Act* are expected to clarify the boundaries of private-pay services within primary health care (Health Canada, 2025a). As private NP practice, including independent clinics and privately funded virtual care, continues to expand, questions arise about long-term implications for accessibility and equity. If private NP practice grows in response to limited public sector flexibility, funding and infrastructure, the public system may face further strain and challenges in recruiting and retaining NPs.

Overall, while new funding models offer opportunities to increase access, particularly in underserved areas, they also present risks related to workload, burnout, fragmentation and inequitable compensation. Given the diversity and rapid evolution of NP practice models in Canada, there is an urgent need for systematic evaluation of how funding structures influence NP role implementation, autonomy, job satisfaction and workforce sustainability.

1. For unions

- Continue to advocate for remuneration that recognizes NP clinical contributions, education, expertise and professional responsibility.
- Ensure that the rights of NPs under collective bargaining are protected during shifts in funding models such as the *Canada Health Act* Interpretation Letter (“Letter to provinces and territories on the importance of upholding the *Canada Health Act* – 2025”).
- Continue to consult with NP members to ensure that ongoing advocacy and bargaining priorities align with a rapidly changing NP practice environment.
- Where these models exist, advocate for compensation that reflects panel size and the complexities of independent practice.

2. For NP employers

- Review and update organizational funding and staffing policies to ensure equitable remuneration and recognition of NP contributions in team-based and roster-based care models.
- Develop transparent processes to track NP workload, patient complexity and care delivery contributions, and use these data to inform funding allocations and workload distribution.
- Provide administrative and clinical support for NPs to reduce workload burden and mitigate burnout.
- Include NPs as key stakeholders in leadership positions throughout the organization.
- Explore flexible and innovative funding models that support NP-led services.

3. For provincial and national NP leaders

- Collaborate with governments, nurses' unions, and employers to develop an NP funding and remuneration framework that is consistent across provinces and aligned with NP scope, autonomy and accountability.
- Advocate for revisions to capitation and blended physician models so that funding reflects the provider delivering the majority of care and recognizes NP clinical contributions, workload, and accountability.
- Develop position statements and evidence syntheses to guide policymakers on emerging funding models and their implications for retention and sustainability.

4. For nurse scientists and NP researchers

- Conduct research to evaluate the impact of emerging funding and reimbursement models on NP workload, burnout, job satisfaction and retention.
- Examine differences in NP experiences between public and private practice models, including compensation, role autonomy, job stability and equity in access to care.
- Investigate patient outcomes, quality of care, and access under NP-led, team-based and privately funded models to identify best practices and inform future health policy.
- Evaluate how federal changes to the *Canada Health Act* influence NP practice environments, funding structures, and the balance between public and private primary health care.

5. For provincial and territorial governments

- Develop NP-specific funding models that recognize the full scope of NP practice, support independent panels where appropriate, and reduce dependence on physician-centric models that obscure NP contributions.
- Revise rostering and capitation policies to ensure that funding follows the provider delivering the majority of patient care.
- Invest in administrative, interprofessional and digital infrastructure support for NPs, particularly those with independent panels or working in rural and remote regions.
- Fund NP continuing educational development programs (e.g., mentorship, residency) in specialized areas of practice.



Recommendation 3: Health human resource planning

Nationally and internationally, there is growing recognition of the urgent need for evidence-informed health human resource (HHR) planning for NPs to ensure stable access to high-quality care. Despite rapid growth of the NP workforce and ongoing expansion of NP scope of practice, Canada lacks coordinated strategies to address current and future NP workforce requirements. Without intentional planning, emerging gaps in NP supply, skill mix, experience distribution and practice support will continue to challenge recruitment, retention and long-term sustainability of the NP workforce (Barnes, 2015; Faraz, 2019; Heale, 2025b).

Quantitative findings from this study highlight critical HHR concerns. Nearly 14% of NPs reported plans to retire within the next year, signaling an impending loss of experienced NPs who carry clinical expertise, mentorship capacity and leadership skills essential for organizational functioning. Between 2020-2024, the number of NPs in Canada has nearly doubled, resulting in a workforce dominated by novice NPs with fewer than five years of experience (CIHI, 2024a). These shifts create a widening experience gap that has implications for workload distribution, clinical decision-making support, quality of care and retention.

Job satisfaction patterns also differed between novice and experienced NPs. Novice NPs reported greater challenges related to role clarity, support for independent decision-making and access to mentorship – factors known to affect job satisfaction, confidence and retention during early transition into practice (Barnes, 2015; Faraz, 2019). Experienced NPs reported higher satisfaction with role autonomy and scope of practice but greater concerns about workload and burnout, linking cumulative workload pressures to emotional exhaustion and decisions to leave the profession (Lockwood & Schober, 2024).

Qualitative data from this study further illuminate transition-to-practice stressors for novice NPs. Many described the early years of practice as overwhelming, citing limited organizational orientation, inadequate mentorship and uncertainty navigating new responsibilities. These findings align with the literature describing transition shock,

heavy cognitive demand and the need for structured support to ensure safe, confident and sustainable early NP practice (Barnes, 2015; El Hussein & Ha, 2022; Faraz, 2019). The presence or absence of transition support directly influences job satisfaction, retention and the likelihood of NPs remaining in their roles beyond the first few years.

The presence or absence of transition support directly influences job satisfaction, retention and the likelihood of NPs remaining in their roles beyond the first few years.

A major concern highlighted is that Canada lacks reliable methodologies to forecast NP workforce needs (Bryant-Lukosius et al., 2026). While the NP workforce has grown rapidly, and NP roles continue to expand across settings, there is currently no national strategy or modeling framework to determine how many NPs will be required to meet future population health needs, demographic changes, service delivery reforms or advances in scope of practice. This gap poses risks for system planning and may result in future shortages, maldistribution of NPs across practice settings, or an inability to match NP competencies with population needs.

Strengthening NP HHR planning is essential to ensure the sustainability of the NP workforce, support safe and effective care, and maximize the health system's return on investment. Doing so requires coordinated action across unions, educators, employers, professional associations and policymakers.

1. For unions

- Advocate for HHR strategies that address both immediate and long-term NP workforce needs, including supports for safe transition to practice.
- Ensure that the goal of collective bargaining is that collective agreements reflect the unique career trajectories and support needs of novice, mid-career and experienced NPs.
- Promote mentorship structures and workload protections for novice NPs to support early-career retention.

2. For NP employers

- Develop and implement structured transition-to-practice programs for novice NPs, including mentorship, orientation and clear role expectations.
- Ensure that transition-to-practice and mentorship initiatives are led by experienced NPs who possess advanced clinical expertise and leadership competencies. Where feasible, organizations should provide formal recognition and appropriate compensation for mentorship responsibilities, acknowledging the additional workload, time commitment and professional accountability involved in supporting novice or transitioning NPs.
- Create succession planning strategies to preserve expertise, clinical leadership and continuity of care as experienced NPs retire.
- Implement workload management practices that reflect differences in NP experience, skill acquisition and panel complexity.

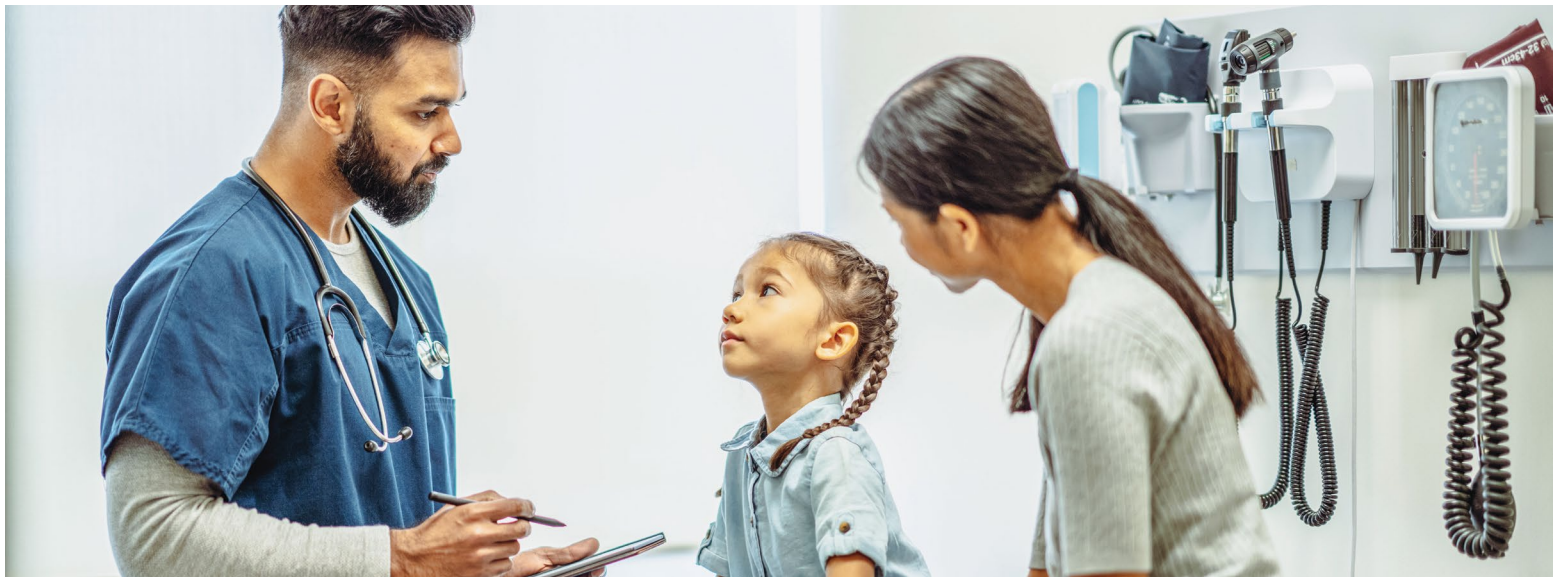
3. For provincial and national NP leaders

- Collaborate with governments and regulatory bodies to establish national HHR forecasting models for NP supply, demand and workforce distribution.
- Advocate for standardized transition-to-practice supports across jurisdictions.

4. For nurse scientists and NP researchers

- Conduct longitudinal studies examining NP workforce trends, retirement patterns and transition-to-practice outcomes.
- Evaluate the impact of mentorship, residency or fellowship models on novice NP competence, job satisfaction and retention.
- Develop and validate forecasting models to estimate the number of NPs required to meet future population health and system-level needs.





Conclusion

Nurse practitioners are a critical component of Canada's health care system, providing high-quality, accessible and patient-centered care across a range of settings. However, rapid growth in the NP workforce, evolving models of practice and diverse funding structures have highlighted significant challenges related to role implementation, job satisfaction, workload and workforce sustainability. Evidence from this study, combined with national and international literature, underscores that strengthening NP work environments, modernizing remuneration and funding models, and implementing comprehensive health human resource planning are essential to optimize NP contributions, improve retention and ensure equitable access to care.

Creating positive work environments that support autonomy, professional growth and work-life balance is fundamental to reducing burnout and enhancing job satisfaction. Aligning remuneration and funding structures with NP contributions, including independent practice and panel-based care, is necessary to promote equity, recognize clinical expertise and reduce role strain. Finally, strategic health human resource planning, including transition-to-practice supports, succession planning and forecasting models, is crucial to address workforce gaps, retain experienced NPs and prepare for future population health needs.

Taken together, these recommendations provide a roadmap for policymakers, employers, unions, professional associations and researchers to collaboratively strengthen the NP workforce. By investing in NPs, Canada can ensure a sustainable, resilient and highly skilled workforce capable of meeting current and future health care demands while maintaining high standards of patient care and professional practice.

Research team

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Appendix

Position funding and remuneration			
How NP position is funded (n = 1,243)	n	%	
Provincial/territorial government	630	50.7	
Federal government	54	4.3	
Regional health authority or Local Health Integration Network	214	17.2	
Publicly funded individual facility	167	13.4	
Private for-profit company	58	4.7	
Charitable/not-for-profit company	12	1.0	
Self-funded through fee-for-service	13	1.0	
Physician funding	31	2.5	
Other	46	3.7	
Educational expenses reimbursed (n = 1,243)	n	%	
Yes, in full	318	25.6	
Yes, partially	532	42.8	
No	367	29.5	
Not applicable	26	2.1	
Days per year	Min	Max	Mean (SD)
Paid vacation days (n = 1,228)	0	50	19.0 (9.9)
Paid personal days (n = 1,106)	0	10	2.1 (2.6)
Paid sick days (n = 739)	0	10	4.8 (4.0)
Paid educational days (n = 1,116)	0	30	3.1 (3.8)



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