Development of a Comprehensive Situational Analysis of Human Resources and Skill Needs of Canada's Health Executive/ Management Sector

For:
The Canadian College of Health Service Executives in partnership with the Academy of Canadian Executive Nurses, Canadian Society of Physician Executives and Human Resources Skills Development Canada

By: Lorna Romilly
Romilly Enterprises

March 9, 2005

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Before undertaking a major sector study of health care executives/managers, the Canadian College of Health Services Executives (CCHSE) along with their partners, the Academy of Canadian Executive Nurses (ACEN), the Canadian Society of Physician Executives (CSPE) and Human Resources Skills Development Canada (HRSDC), wished to address the knowledge gaps about the present and future leadership/ management cohort in health care and carry out a situational analysis to: (1) identify key data and information requirements; (2) collect and review existing information on leadership and management in the health care sector; and (3) identify and explore the barriers/opportunities that would affect the feasibility of conducting a full study of the Canadian health leadership/management sector.

The availability of key data and information requirements was examined around four factors in a health human resource framework developed by O'Brien-Pallas et al: human resource planning and forecasting for health executives/managers, their supply; their production, i.e. education and training; and the management, organization and delivery of health services or the workplace environment in which they are asked to work.

There are many limitations to data collection on health executives. No regulatory/licensing authorities are required in which they all have to register so governments, data collection agencies such as the Canadian Institute for Health Information (CIHI) and others use administrative data maintained by health professional associations and Human Resources and Skills Development Canada (HRSDC) and Statistics Canada combines data on health executives with other industries in some of their categories. For this project material from a number of reports, articles, interviews and web-sites was collected.

Key data and information requirements

HRSDC collects data nationally, in their National Occupation Classification system, on several categories that include health care managers but other managers are included in some of their groupings. Mainly what we know occurs in provincial pockets of information interspersed with vast amounts of white space. The first issue to examine is who would be the subjects of such a sector study, i.e. who are Canada's health executives or managers. Defining a health care leader, executive or manager is not straight forward. Definitions used by the federal government and research groups may be too limiting while those put forward by health executives and others may be too broad, or not concrete enough to develop categories for collecting data. Titles for the most senior position in health care organizations are pretty uniform across the country: President, CEO, Executive Director, Administrator and even the second-in-command positions are quite similar. When you start to examine the positions below those two levels, defining the position and scope of work varies considerably across the country as does the way provincial health services are organized. In addition there are issues around the inclusion of clinical executives – how much administration do they have to do to be considered among this group? Should clinical nurse specialists who act in a consulting role or in non-management leadership positions be included? What about staff specialists who manage or consult on processes – human resources personnel, information system people who may not have anybody reporting to them? So the first issue is to achieve a consensus

on definitions that allow for management principles, leadership, and concrete ways of describing these positions so they can be counted, studied, compared and analyzed.

Health Human Resource Planning and Forecasting

Health human resource issues have been identified by all groups as a key priority. Many studies argue for system-wide change in the way health human resource planning is done and for integrated planning but they usually only refer to clinical professionals. Health executives are being considered as part of some future integrated studies. There is much agreement on health human resource (HHR) planning as a key issue and some work on trying to bring all of the stakeholders together but many barriers to coordinating HHR planning and the collection of data nationally, particularly for health executives.

Gaps in existing data: What model for forecasting and data collection will help us project future needs for health care executives/managers?

Supply – Is there a "Looming Leadership Crisis"

What evidence is there about a current or future shortage of health care executives? There is conflicting opinion among those interviewed – on the one hand senior executives and other managers are aging; on the other amalgamation of services and cost-cutting have led to fewer executive/manager positions. Part of the problem in identifying shortages relates to a lack of common standards defining adequate staffing levels. No one has studied health executives nationally. A survey in Canada of 108 CEOs in 2001 found 31.5% of this group was over 55; only 9% were 35-44 suggesting a small pool of future leaders. Provincially there have been only three complete sector studies: in Quebec, Nova Scotia and Newfoundland. In Quebec 50% to 72% of senior managers will be reaching retirement within 5 to 10 years and the system is having difficulty recruiting and retaining well-trained managers but with the current reduction of 160 hospitals to nine health authorities and with the new CEOs being in their 40s what was thought to be an issue may not be one now. In Newfoundland 50% were over the age of 45 with a turnover rate of 16%. The average age of managers in Nova Scotia was 47.

What about leadership? Some of those interviewed thought the quality of applicants for senior positions had decreased and expectations were rising; jobs were larger in scope. People are leaving the system because the pressure is too high and the time commitments are very heavy. Some thought senior people were not delegating to lower levels and grooming and mentoring people.

There is evidence of reduced numbers in some provinces and of an aging health executive group but the confounding factor of changes to the delivery system creates conflicting impressions about the issue. There is no convincing national data that there is a "looming" crisis or shortage or not.

Gaps in existing data:

- How many health care executives/managers work in the health system in Canada
- How many we will need in the future
- How many will be retiring in 5 years; 10 years

- What is common and different among health executive roles and functions in various settings
- Has restructuring really changed the need for numbers of managers?
- What are optimal numbers?
- Do we really have a shortage?
- Common measurement tools to be able to analyze workforce needs

Production of Health Service Executives/Managers

The production of health service executives/managers, their training and education, leadership development, coaching and mentoring even succession planning, assumes we know what the competencies, i.e. knowledge, skills and attributes, are to do the job. There is great disparity in education at the management level across the provinces. In the survey of 108 Canadian health care CEOs 80% or more of the CEOs responding (many from Ontario) had received Masters level designation. In the Newfoundland study 67% indicated their highest level of education was either a Certificate/Diploma or a Bachelor's degree. 19% held a Masters degree.

The competencies needed by executives/managers to lead in the future have been discussed in many articles and books for years and more recently in Canadian health care literature and symposiums. In addition concepts of leadership are constantly changing. A number of competencies are supported in current literature: strong communication skills including moving a vision forward; a commitment to the consumer; effective relationship building; systems-thinking; managing change and transition; critical thinking skills; the ability to manage the culture; the effective use of resources and the ability to manage themselves. To validate a set of competencies, though, for a complex field such as health care may be slow. There have been no studies in health care organizations which identify the results or success of particular competencies or skills.

Formal training seems to be the primary way of developing leaders in health care; some argue that we need more practitioner-based learning that focuses on experiential learning with opportunities to reflect upon and refine emotional responses to situations that call for leadership. The five stages of skill development have been proposed where people move from being a novice to an advanced beginner to competent to proficient to expert, becoming experts only by learning on the job.

Canadian health care organizational experience with formal succession planning appears to be limited. There have been a number of recommendations in studies but there is not much information on any activity. The impression of those interviewed is that people are not looking at the potential internally or rotating managers through jobs to get broader experience; boards are not bringing in new blood. One suggestion also was that we have to rethink what we mean by succession planning because the days of the 30-year employee are gone.

Are we producing enough health executives/managers with the right competencies to be able to meet the demand to lead Canadian health care organizations in the future? We don't know.

Gaps in existing data:

- Trends in hiring new Canadian health executives/managers

- Key competencies that Canadian health executive/managers must have
- Which degrees are desired? Which have proven to provide the best background, are the most successful?
- What leadership development is occurring now in health authorities, health organizations?
- What recruitment and retention strategies work for this sector?

Management, Organization and Delivery

The quality of working life, how the system is organized and the design of management positions all have an impact on health executives/leaders' ability to do their jobs. The number of reorganizations and cutbacks in many provinces has created turmoil for many years. Senior positions have become much more political; there is more and more micro-management from governments who have not hesitated to interfere in the workings of health authorities and organizations. The survey of 108 Canadian health care CEOs found that the flattening and reduction of senior management structures meant more work and responsibility for the CEO and they spent more time lobbying and responding to demands for accountability. One study on nurse managers' health found that a lack of necessary information, resources and support to perform their role effectively put nurse managers at risk for developing emotional exhaustion. The Quebec study found that the health system has not recognized the strategic importance of its human resources and the development of stimulating work environments to sustain the best people. In the Nova Scotia study the quality of work life in health care organizations was thought to be a significant factor in recruiting and retaining people.

Gaps in existing data:

- What types of organizational design of health organizations occur across the country and what impact do they have on numbers and types of managers? For example: does program management require more clinical managers, fewer managers, etc?

Barriers to Conducting a Full Study

Many of the barriers are around data challenges. Data is incomplete and inconsistent and there is no commitment to a common standard or common data gathering system. A number of limited datasets are being maintained, not linked, and are usually designed for a purpose other than planning. Health organizations have multiple human resource software systems. Finding the data will also be a problem unless we register and regulate the profession. The Nova Scotia study points out that there is no nationally recognized set of data elements for HHR planning for health professionals. National organizations like CIHI are working to address data issues in HHR planning, but they are dependent on the accuracy of input from the provinces. Confidentiality is also a key issue. Education and training information on funding programs, students, enrolments, and faculty is not available from a central source.

Other challenges include:

- Complexity which often defeats a comprehensive approach – different level of standards; different visions; poor communication

- Accountabilities in health human resources are diffuse and there is no coordinating mechanism to pull them together.
- Lack of political will to build appropriate national information systems.
- Policy levers (education and training, pricing for services, location of services, types of services, regulation of services) are in multiple hands with a large amount of goodwill required and voluntary cooperation even within a profession, says CIHI.

Opportunities/Innovations to Think About

There are also some opportunities and innovations that may assist say Fooks et al:

- Funding earmarked for national coordination and planning
- Linkage of health human resource planning to system design issues in the advisory structure of the Conference of Deputy Ministers.
- Intergovernmental dynamic may change with political changes at federal and provincial levels
- Priority setting exercise by national health service research organizations has identified health human resource planning as the number one research priority
- Substantial investments in health human resource modeling and policy research – stronger and larger research community interested in linking with decision makers to support evidence-based policy.
- Pan Canadian Health Human Resources Strategy

Conclusion

There are a number of questions and key issues to discuss around human resources and skill needs of Canada's health executive/management sector. Existing information on the supply and production of leadership and management in the health care sector is sparse and inconclusive. Despite numerous reports about human resource planning for health professionals, health executives have only recently been included in the discussions and activity has been slow to get started. The current organization and environment of the health care work place appears to be problematic for the recruitment and retention of leaders. Despite the data and other challenges to conducting a full sector study there are some opportunities that might assist the industry to find some answers.

1. BACKGROUND

The absence of a Canadian study addressing executive and management leadership issues has created a lack of critical information for health human resources planning purposes. "Canadian researchers have characterized health human resource planning as a 'classic policy soap opera – tune out for a few years and there is a reasonable chance that not much will have changed when one returns'."[1]

Given the transformation changes that are occurring in the health care system there is concern that the future will require a different set of leadership competencies and that there will be a shortage of people equipped to master the essential components of senior leadership in large and complex organizations. There is also a growing concern about the future challenge of recruiting and retaining qualified leaders in health service organizations with a number of factors contributing to the diminishing appeal of health services management as a career option. Health care is not alone in this. CEO turnover is increasing in business with large business firms failing more frequently. "In 2001, less than one-half of the American and European CEOs who stepped down from their jobs did so as part of a planned succession process. Contrast this with 1995, when 72 percent of departing CEOs left under the terms of formal transition plans."[2]

The Canadian College of Health Service Executives (CCHSE) in partnership with the Academy of Canadian Executive Nurses (ACEN), the Canadian Society of Physician Executives (CSPE) and Human Resources Skills Development Canada (HRSDC) recognize the importance of undertaking a leadership development initiative in Canada. Before such a project can be launched, however, there is a pressing need to first address significant knowledge gaps about the present and future leadership/management cohort in health care.

The review of human resource issues relating to health system executives is a key step in identifying health human resource needs and issues associated with management and executive leadership to ensure there will be an adequate "pool" available to sustain the health care system in Canada. A proposed project focuses on obtaining data that will project:

- When the current cadre of health care system leaders and managers will be leaving the field;
- Identified likely replacement pools (i.e. how many are expected to be available relative to the need; is retention more of an issue than shortage?); and
- The capacity to handle current and future demand.

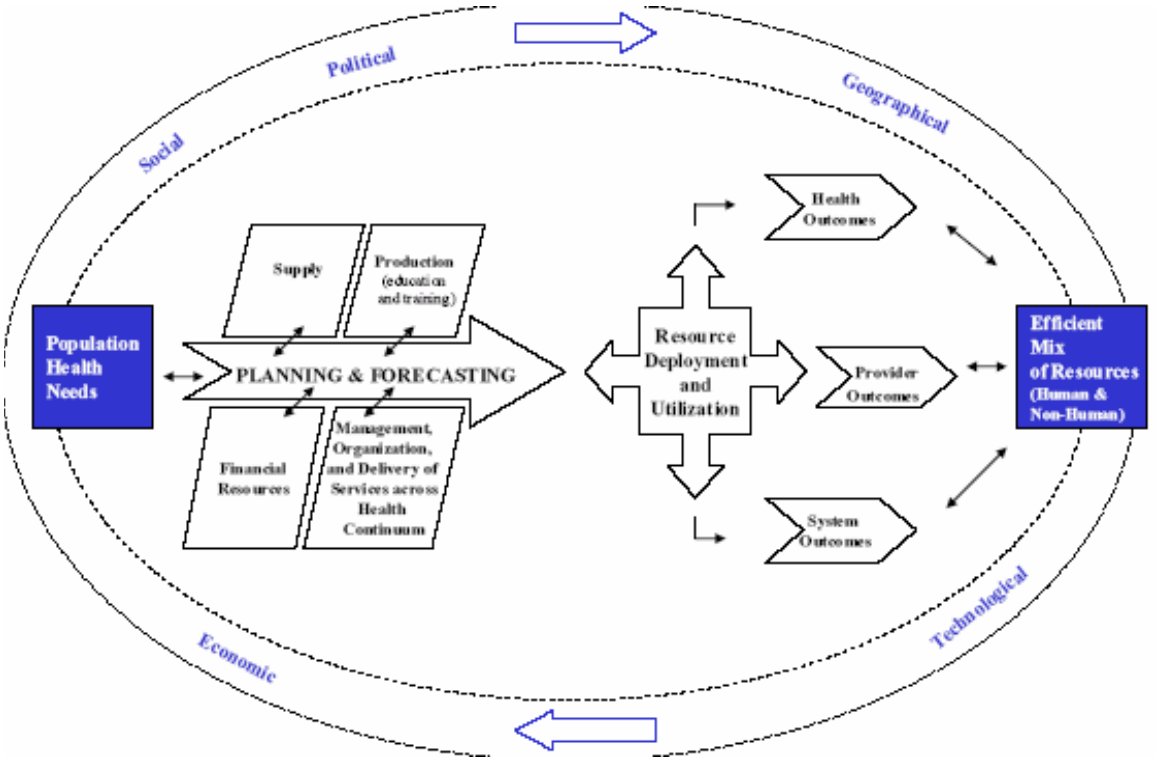
This situational analysis was carried out to:

- Identify key data and information requirements;
- Collect and review existing information on leadership and management in the health care sector; and
- Identify and explore the barriers/opportunities that would affect the feasibility of conducting a full study of the Canadian health leadership/management sector.

2. HEALTH HUMAN RESOURCES CONCEPTUAL FRAMEWORK

Many analytical health human resource frameworks/models have been developed, in Canada, in an effort to understand the complexity of inputs, outputs and interactions. The following framework, developed by O'Brien-Pallas, Tomblin, Murphy, Baumin and Birch is an example used by Stats Canada and Canadian Institute for Health Information.[3]

Figure 1
Health Human Resources Conceptual Framework



The model shows the connection between factors influencing the supply and the demand for health personnel within the context of a complex environment.[4] This project focused mostly on collecting available data and reports on supply and production of health executives with some search for data around management, organization and delivery of services and the relationship of these to the supply. For the purposes of this paper human resource planning and forecasting is included but not financial resources. Some of the barriers found to a complete analysis relate to the context shown in the outside circle.

3. DATA COLLECTION & SCOPE OF THE PROJECT

There are many limitations to collection of data on health executives. There are no regulatory/ licensing authorities for health executives/managers and even secondary sources such as CIHI use the voluntary membership of the CCHSE as a proxy for number of health care managers in Canada. CIHI says because membership is voluntary, and not regulated, the numbers may be underrepresented and inaccurate. "For most health personnel groups, outside of physicians and nursing, national standards for data collection do not exist and there are data gaps in areas such as demographics, education/training and practice information." Governments use the administrative data maintained by health personnel associations also. "More often than not, these data are found to be inadequate for even the most basic information-based functions of HHR management, let alone more advanced modeling/projection activities."[4]

Sources of data on the supply of the health executive/management sector can come from administrative sources collecting data for membership or business purposes. Primary sources include regulatory/ licensing authorities, educational training institutions and voluntary membership associations such as the CCHSE. Secondary data collection can come from groups like CIHI's databases. Data can also be collected from broadly based national surveys such as the National Occupational Classifications from HRSDC and Stats Canada's Labour Force Survey and profession specific surveys such as Quebec's Centre de référence des directeurs généraux et des cadres study of their province's health and social services executives.[5] [*] HRSDC has at least five categories which include health care managers in its NOC, some of which include other managers, and Statistics Canada has three categories for health managers, two of which include education and social services which CIHI says is "…too broadly based to provide a reasonable comparison to [Health Personnel Database] HPDB data."[4] While there is a great deal of discussion about nursing and physician shortages on provincial government websites and in many Canadian reports, only a few provinces seem to have done detailed studies on health executives.

For this project it was decided to analyze and synthesize material from a number of reports, articles and interviews under the following themes: health human resource planning and forecasting, supply of health executives/managers; production; and management, organization and delivery of health services across the continuum and the workplace environment.

Data collection included:

- Review of web-sites of Canadian health research organizations, health associations, health executive/management associations, provincial/territorial/federal ministries/departments of health to determine if there were reports/activities on health executive/ managers or relevant health human resource issues.
- Review of the web-sites of publishers of a number of journals such as Longwoods Publishing, Academy of Management, American College of Health Executives
- Review of relevant refereed and non-refereed articles, research studies and reports
- Telephone interviews with 10 stakeholders.[†]

[*] Sources of data and other information used in this document are documented further in the Annotated Bibliography (See Appendix A).

[†] The summary of information from the interviews is in Appendix B

4. WHAT DO WE KNOW ABOUT CANADA'S HEALTH EXECUTIVE/ MANAGEMENT SECTOR

While there have been many studies discussing health human resources (HHR) planning, primarily for physicians and nurses, there have been only a few national surveys in the past with a small number of respondents. Mainly what we know about Canada's health executive/management sector occurs in provincial pockets of information interspersed with vast amounts of white space. Uniformity of definitions and data collection systems are major issues.

4.1. Definitions

Defining a health care leader or manager is not straight forward. Definitions used by the federal government and research groups may be limiting while those put forward by health executives and others may be too broad, or not concrete enough to develop categories for collecting data.

Since its introduction in 1992, the National Occupational Classification (NOC) system of the Department of Human Resources and Skills Development Canada (HRSDC) has been an authoritative resource on occupational information in Canada. The NOC 2001 is based on extensive occupational research, analysis and consultation conducted across the country. It's 2001 classification has some categories which include health executives/managers, depending on the definition: 0014, 0411, 0311, 3151 and 4165:[6] There are problems with some of these classifications, however, as there are other titles included which are not health care. The categories which include health care executives/managers follow. (A complete listing of all of the health care related titles for these categories can be found in Appendix C.)

- **0014 Senior managers – health, education, social and community services and membership organizations.**

  "Senior managers in this unit group plan, organize, direct, control and evaluate, through middle managers, membership and other organizations or institutions that deliver health, education, social or community services. They formulate policies which establish the direction to be taken by these organizations, either alone or in conjunction with a board of directors. "

  There are 84 titles in this category of which 43 appear relate to health care organizations. Included in this grouping are CEOs, president, hospital administrators, vice presidents, CFOs, executive directors, assistant executive directors, general managers, association executive directors; however, it also includes titles such as president music guild, president labour association, business school general manager.

- **0411 Government Managers – Health and Social Policy Development and Program Administration**

  "Government managers in this unit group plan, organize, direct, control and evaluate the development and administration of health care policies, social policies and related programs

designed to protect and promote the health and social welfare of individuals and communities. These managers are employed by government departments and agencies."

There are 174 titles in this classification of which 48 appear to be related to health care. Included in this grouping are titles such as director, health information and promotion – government services, director health services – government services, director homemaker services – government services; however, the group can also include titles such as immigrant settlement director – government, social services director - government, administrative tribunal judge – government.

- **0311 Managers in Health Care**

"This unit group includes managers who plan, organize, direct, control and evaluate the delivery of health care services, such as diagnosis and treatment, nursing and therapy, within institutions that provide health care services. They are employed in hospitals, medical clinics, nursing homes and other health care establishments."

All of the 135 categories relate to health care but it is impossible for the list to be inclusive as titles constantly change in health care, for example this NOC doesn't include professional practice leaders, program managers, quality improvement managers, and other more recent titles. It includes titles such as chief of medical staff, mental health residential care program manager, admissions director – health care, assistant director nursing services. HRSDC says using this code for 2001 there would be approximately 20,900 managers.

- **3151 Head Nurses and Supervisors**

"Head nurses and supervisors supervise and co-ordinate the activities of registered nurses, licensed practical nurses and other nursing personnel in the provision of patient care. They are employed in health care institutions such as hospitals, clinics and nursing homes and in nursing agencies."

There are 34 of these titles which include for example: coordinator of nursing services, assistant head nurse, nursing supervisor, operating room head nurse. In 2001, there were 15,700 persons in this grouping.

- **4165 Health Policy Researchers, Consultants and Program Officers**

"Health policy researchers, consultants and program officers conduct research, produce reports and administer health care policies and programs. They are employed by government departments and agencies, consulting establishments, universities, research institutes, hospitals, community agencies, educational institutions, professional associations, non-governmental organizations and international organizations."

There are 57 titles in this category of which 45 might be considered as health managers, depending on our definition. They include titles such as consultant health care planning, health care planner, health promotion program officer, officer health policy development but also include titles such as drug and alcohol abuse consultant, dental health consultant which are not always considered management positions.

Stats Canada[7] defines managers in health (and includes the public sector and education), in three standard occupation classifications (SOCs) that are the same as the NOC:

"Senior managers in this SOC unit group (A014) plan, organize, direct, control and evaluate, through middle managers, membership and other organizations or institutions that deliver health…services. They formulate policies which establish the direction to be taken by these organizations, either alone or in conjunction with a board of directors."

Managers in this unit group (A321) include "…managers who plan, organize, direct, control and evaluate the delivery of health care services, such as diagnosis and treatment, nursing and therapy, within institutions that provide health care services. They are employed in hospitals, medical clinics, nursing homes and other health care establishments." Included in this group are administrators, assistant administrators, chief of …, director of …, manager, health educator.

Managers in the health care sector who are responsible for activities other than the delivery of health care services are classified in unit group A331 – government managers in this group "…plan, organize, direct, control and evaluate the development and administration of health care policies, social policies and related programs designed to protect and promote the health and social welfare of individuals and communities. These managers are employed by government departments and agencies." Included in this group are directors, assistant directors, chief, manager, administrator.

The definition that the Canadian Institute of Health Information (CIHI) uses is:[4]

"A health service executive assumes a leadership role in a management position in the Canadian health system."

The executive's responsibilities/activities: "leads the part of the system for which he/she is responsible to ensure that the service within his/her area of responsibility is provided with the highest quality, with best use of available resources, in an environment that is conducive to good employee morale and that is synchronized with other parts of the health system."

The practice setting may be "an organization that provides health care services to Canadians (e.g. hospitals, Regional Health Authorities, local health clinics, etc). He/she may work in an organization that helps to plan for such services (i.e. Departments of Health, consulting firms, etc.). He/she may work in an organization that develops/influences policy (health and/or financial policy) that affects the Canadian health system (e.g. Departments of Health, health associations, etc. Finally, he/she may work in organization that provides products or services to

> the Canadian health system (e.g. lawyers that practice health law, companies that deliver services within health care organizations on a contract basis, etc.)."

A survey of 108 Canadian health care CEOs showed that there was a large degree of uniformity in titles for health care CEOS: President and/or CEO, Executive Director, Administrator [8] and Directeur Généraux in Quebec. Even at the second-in-command level, i.e. Vice President, Chief Operating Officer, Chief Financial Officer, Assistant Executive Director, Assistant Administrator labels are quite uniform. However, for the positions below the two most senior levels, titles and defining scope of work are more problematic and vary considerably across the country, for example, those responsible for a program across a region have large budgets, with many facilities and with a large number of people reporting to them.

The Quebec commission on the study of the health and social service sector describes CEOs and first-level managers, in more modern terms, as follows:

> "First-level managers will act as facilitators for interdisciplinary teams. They will encourage initiatives and foster the emergence of projects aimed at improving practices, based on client needs. Professionals and managers will openly discuss desired results and the expected contribution of all participants. They will work together in a climate of cooperation, evaluating the results of interventions and needs for improvement."
>
> "…Heads of institutions will be increasingly called upon to meet real managerial challenges: defining an inspiring vision and communicating this to all members of the organization, offering motivating leadership, placing value on the contribution of each player, and ensuring that the organization contributes fully to the achievement of regional and national objectives. The great strength of management teams will be expressed, above all, through their capacity to create a climate of confidence and to instill in others the desire to succeed. Their main objectives will be to anticipate change, offer direction and mobilize the energy of all players around stimulating projects which are beneficial to the population, as well as to internal partners and to the whole of the health and social services system."[9]

The inclusion of facilitation and fostering cooperation, creating a climate of confidence and anticipating change are described as current competencies in many articles on leadership. Those interviewed defined a health care leader or manager, in similar ways, as someone responsible for achieving outcomes or results through the work of others; someone who sees the big picture, has a vision and transposes it to those they are leading; has a bit of content knowledge but able to bring broader perspective; a negotiator; able to deal with ambiguity and "connect the dots when there aren't any". Others said the leader is one with communication skills, assertiveness, decision-making, and conflict management skills. Discussion at the CCHSE Leadership Symposium suggested that consensus around a new leadership profile would help determine the requisite leadership skills. Participants said leaders are able to motivate the workforce, pass on clear goals, focus on enabling the success of others, and create supportive and caring environments.[10]

Hudson distinguishes between leadership and management by saying that "creating and enunciating an innovative vision and the ability to inspire people to move areas to which they don't want to go, are key

elements of leadership. Management is characterized by operationalizing the strategies that are created by the leader to support the innovative vision."[11]

Any definition has to include those who manage processes, i.e. staff roles and clinical managers, who have additional responsibilities to their management role. One study, conducted in Ontario hospitals, discusses the emergence of non-management leadership positions to support professional practice. "With the elimination of profession-specific management positions, the need for profession-specific leadership has been met by creating a model of advanced practice leadership positions." These senior clinical positions described in nursing literature, have also been described for other health professions.[12]

The Leadership Institute of the National Health Service's Modernisation Agency in the UK describes a leader as someone who is responsible for the quality of health outcomes and the quality of health service delivery, with 'quality' being the operative word. The NHS finds some key themes on leadership in their research:

- Leadership is value added activity
- Leadership is always future focused – it means working to ensure the future is better than the past or present.
- Leadership takes many different forms
- Leadership can and should operate at all levels in an organization; the content and scope of leadership activity will vary, but leadership qualities and processes will be essentially the same
- Effective leadership in modern, complex, multi-stakeholder organizations depends crucially on building effective relationships with others.[13]

The health care industry, perhaps together with health human resource researchers, will have to decide on definitions that allow for both modern management principles and concrete ways of describing these positions so they can be counted, studied, compared and analyzed.

4.2 An Overview of Initiatives on the Canadian Health Executive/Management Sector

There have been many reports on nursing human resource issues and some on physician resource issues but there are not very many on the Canadian health executive/management sector. Occasionally health care executives merit a comment in other reports or are grouped with other sectors, such as the public sector or education. The following table provides an overview of the initiatives or reports found dealing specifically with the Canadian health/executive management sector. They have been categorized in the theme areas though they sometimes cover more than one area, such as supply and human resource planning.

Table 1

An Overview of Activity Nationally, Provincially and in Territorial Jurisdictions on the Canadian Health Executive / Management Sector

Domain	Activity		
	National / Federal	**Provinces / Territories**	**Associations / Research Groups**
Health Human Resource Planning and Forecasting (for Health Executives) (includes Succession Planning)	**Health Canada Pan Canadian Health Human Resources Planning-** Health Canada is working with the provinces, territories, and key stakeholders to determine how best to respond to the call for a more coordinated, pan-Canadian approach to evidence-based HHR planning. **The Advisory Committee on Health Delivery and Human Resources (ACHDHR)** has been a major conduit for the collaborative work that has taken place in 2003/04. The ACHDHR is a Federal/Provincial/ Territorial Advisory Committee reporting to the Conference of Deputy Ministers. The mandate of this group is to provide strategic evidence-based advice, policy and planning support on HHR planning matters to the ACHDHR; and to serve as a linkage to other initiatives	*A Study of Newfoundland and Labrador's Health and Community System Managers*. (2003) A **Report of the Management Survey and Audit**, April 7. - Purpose of the study was to create a demographic profile of health and community system managers and identify key issues facing this group. [14] **Newfoundland and Labrador Health and Community Services Human Resource Planning Steering Committee**. (2003) *Final Report*, July - Health and Community Services Human Resources Sector Study – includes recommendations on integrated planning, system leadership, succession planning and appropriate supply.[15] **Northwest Territories Health and Social Services** *Action Plan*, 2002-2005 Status Report April-September, 2003 – says that a comprehensive system-wide human resource plan has been developed; competency modules for management and human resource positions are being developed and government-wide parameters and activities for succession planning. A Management Assignment Program started in June, 2003 as part of succession planning[16] **Commission d'étude sur les services de santé et les services sociaux. Québec**. (2001) *Emerging Solutions. Report and Recommendations* - 50% of the senior managers will be reaching retirement age within 5 years; difficulty recruiting and retaining well-trained managers and a section on governance: clarifying roles and strengthening the accountability of senior administrators. Recommends that the Ministry develop a program aimed at preparing future executive directors.[9]	***Centre de Référence des Directeurs Généraux et des Cadres*** –conducted a study, published in November, 2001, on health and social service executives/manage-ment requirements in Quebec which looks at the period from 2000 with planning to 2010. [17] *Hospital Report* (**Ontario**), 2003 - "75% of hospitals [in Ontario] reported having a formal interviewing process for physician leadership positions ….Only 27% of hospitals had succession plans for senior management positions."[18] CCHSE working with 30 national healthcare organizations to develop a more coordinated approach to the national HHR effort[19] In conjunction with ACEN and Canadian Association of Physician Executives and others, the CCHSE is proceeding with a project that will address current and future challenges for the health management profession[19]

Domain	Activity		
	National / Federal	**Provinces / Territories**	**Associations / Research Groups**
Supply		**Nova Scotia Department of Health** -a Study of Health Human Resources in Nova Scotia, 2003 has several sections which include data on health managers – looks at characteristics of the workforce, supply issues, education, and the quality of work life. **Quebec**, 2001 – Study of Health and Social Service Managers - 72% of those in management positions will need to be replaced by 2010.[20] BC used to have *Roll Call*, produced by the Health Human Resource Unit of UBC and started by the Ministry of Health which counted health executives biennially. Discontinued in 1999 by the MoH due to cutbacks.[21]	*Environmental Scan on Health Service Research Priorities* for the **Canadian Health Services Research Foundation** - health human resource issues #1 research priority – need for reliable forecasting; redressing shortages and leadership vacuum.[22] *Listening for Direction,*5 partners of gov't and research groups - identified 15 themes as priority areas for the next two to five years - health human resources number one priority – concerns about leadership vacuum within management and policy-making organizations. [23]
Production	*The Changing Role of Canadian Health care CEOs: Results of a National Survey*, 2001 – covered career preparation, skills and attributes, past present and future (108 CEOs participated) – survey sample small, limiting applicability but results are suggestive – also covers aspects of other domains[8]	A number of University programs in health administration and business programs and executive programs across the country– no central way to collect data on those who become health executives	**The Executive Training for Research Application (EXTRA) program** Partnership of CHSRF and CCHSE – 2 year fellowship program designed to teach senior health executives how to apply evidence from health services research to their daily work. CCHSE strategic alliance with CAHSPR to build stronger bridges between research and practice[19] CCHSE has initiated a $1M fundraising campaign to endow a new Canadian Centre for Health System Leadership[19] CCHSE working with many partners to

Domain	Activity		
	National/Federal	**Provinces/ Territories**	**Associations/ Research Groups**
			expand leadership training opportunities for health executives.[19]
Management/ Organization and Delivery of Services			CCHSE's Health System Update on all of the provinces has a section on governance and management[24] CCHSE and others exploring development of a preferred employer/employee of choice program for Canada.[19]

4.3 Health Human Resource Planning and Forecasting

Fooks[25] summarizes the rational for human resource planning and what has happened over the last four years. She suggests a national health human resource planning focus to consider the effects of policy reforms such as restructuring and cutbacks on people working in the system. Also the issues are complex and interdependent occurring in multiple jurisdictions with unclear accountabilities and different governments doing different things while educational institutions do something else again. "National planning would require viewing personnel as assets not cost centres and would require federal provincial cooperation." Several commissions in health care have supported strong integrated health human resource planning. Previous studies include those from Human Resources Development Canada (HRDC) which sponsored "…five health sector studies of labour market issues (although each was independent of the others)." In 2003 the First Ministers Accord also states that collaborative strategies are to be undertaken to:

- Strengthen the evidence for national planning
- Promote inter-disciplinary provider education
- Improve recruitment and retention
- Ensure the supply of needed health providers.

In addition to these activities the 2003 federal budget committed $85 million over 5 years "…to improve national health human resources planning and coordination, including better forecasting of health human resource needs."[25] The 2004 First Ministers Agreement and the 2005 budget also included health human resources issues.

Pong and Russell also neatly summarize much of what has been done in health workforce planning as follows:

> "Health workforce planning, at both the provincial/territorial and national levels, is … complicated by the large number of people, groups, and organizations that have a stake in the matter: ministries of health, ministries of education, universities and colleges, health-sector employers, professional associations, regulatory bodies, labour unions, health services planning agencies, consumers, etc. Furthermore, there are scores of health occupations and health workforce planning has tended to be occupation/discipline-specific, resulting in duplication of effort, competition, lack of coordination, repetition (revisiting the same issue over and over again), and occasionally complete confusion."[26]

Forecasting, historically, has focused on physician resources and more recently, models for nursing resources. Four approaches have been identified: supply forecasting; utilization or demand forecasting; needs-based planning and benchmarking:[1]

- Supply forecasts count the number of personnel at a given time and project forward based on being able to maintain the same level of resources. Its usefulness is limited because it doesn't take into account external environments or that needs may be different in the future.[27]

- Utilization or demand forecasting attempts to match counting the numbers with some measure of population service use – for physicians often converted into a physician per population ratio. Using demand forecasting for health executives/managers is difficult because the number of health executives/managers required to meet population needs or even organization needs is even more unknown than number of physicians.

- Needs-based planning – based on population needs, matched with levels of service used, matched to numbers of personnel – might be more appropriate if we knew how many managers are needed for what types of service.

- Benchmarking starts with examining communities with the lowest number of personnel per population and capital inputs where health outcomes are thought to be optimal and then uses that ratio as a benchmark.

Health Canada, responding to a common theme, in a number of HHR studies, is working with provinces, territories and key stakeholders, through the Pan-Canadian Health Human Resources Strategy, and with CIHI to establish indicators and data elements for a National Minimum Data Set for Health Human Resources in Canada designed to provide a common set of information for HHR research. Health Canada has also" …contracted the Centre for Education Statistics (CES) at Statistics Canada to study the interface between education and training and the supply of health care professionals. Through research and consultation, CES will investigate the availability of data to measure the flow of individuals through education and training and into the labour market. CES will also be able to identify gaps in data and recommend strategies to fill these gaps and meet data needs." Health occupations for consideration are mostly regulated professions but they also have the category of "health service executive". Instructional programs they will be examining include "Health/Health Care Administration/Management, Hospital and

Health Care Facilities Administration/Management, Health Unit Manager/Ward Supervisor, Medical Office Management/Administration." They identify that both Classification of Instruction Programs (CIP) and National Occupational Classification (NOC) codes can present challenges as they are very general (non-specific) for the health service executive group.[28]

Many studies[1] argue for system-wide change in the way health human resource planning is done by governments, educators and stakeholders but they usually refer only to clinical health professionals. They argue for a Canada-wide effort to balance supply and demand nationally. Fooks et al and others [1 29] recommend four key shifts in thinking, two of which apply to health care managers/executives:

- integrating health human resource planning into overall system design choices
- national cooperation/coordination to share information, track trends; develop planning tools; identify practice style, environmental, legislative or educational changes needed.

Fooks et al's report says there is no sign of inter-provincial cooperation on health human resource planning and found that there is limited evidence that the system understands the need to link health policy decisions to human resource issues.

Planning and modeling methods for health human resource planning are broadening to encompass more variables and to include system factors. "…Researchers are proposing new ways of generating information such as minimum data sets to support work force planning rather than specific models, developing health human resource indicators to monitor shifts and trends in the health care work force, and establishing longitudinal cohort studies."[30] Mostly this has been done for clinical health professionals.

In the most recent agreement, on a 10-year plan to strengthen health care, among the First Ministers of federal, provincial and territorial governments, there was agreement to increase the supply of health professionals, based on their assessment of the gaps, including targets for training, recruitment and retention by December 31, 2005. The federal government also committed to participating in health human resource planning with interested jurisdictions; however, they refer to the supply of health professionals as including doctors, nurses, pharmacists and technologists.[31] Health executives/managers are not mentioned specifically.

An environmental scan conducted by the Canadian Policy Research Networks for the Canadian Health Services Research Foundation (CHSRF) states that "*health human resource issues* have unequivocally been identified by virtually all groups as a key priority for health services research….and issues identified focused on recruitment, retention, quality of the workplace and planning models." HHR issues were not a priority in a similar study in 1997. Regional health authorities and hospitals reported on the need to develop reliable forecasting approaches and strategies for recruitment and retention. One of the priorities, for regional health authorities and teaching hospitals, mentioned briefly under health human resources is "redressing shortages: nurses, doctors and health administrators." Another under health human resources mentioned by national non-government organizations working in health was "senior managers and the new and evolving system (training, development issues) and redressing the leadership vacuum."[22]

CHSRF followed this environmental scan with a consultation on the strategic issues facing the health sector with the collaboration of four other partners: the Advisory Committee on Health Services of the Conference of Federal/Provincial/Territorial Deputy Ministers of Health, the Canadian Coordinating Office for Health Technology Assessment, the Canadian Institute for Health Information (CIHI) and the Institute of Health Services and Policy Research, part of the Canadian Institutes of Health Research (CIHR). Two of the illustrative questions, used for the consultation, relate specifically to managers:

- What incentives and strategies will improve the recruitment, retention and leadership capacity of health system managers and policy makers?
- How can the particular health human resource needs of rural and remote regions and of particular marginalized and under-served groups be met in a sustainable and cost-effective manner.

Fifteen themes emerged from this consultation with health human resources being seen as the dominant issue for the next two to five years in this and CHSRF's Roundtable on Integrated Health Human Resource Planning.[23] [32]

At the provincial level, Quebec and Alberta's reports say that workforce planning should become an integral part of strategic planning for all health institutions and they developed a comprehensive health workforce framework plan.[9] [33] [34] Alberta's report includes recommendations on developing human resource systems with common measurement tools to be able to systematically analyze workforce needs and data providing a common definition and categories of a full-time equivalent (FTE) employee along with well defined payroll costs.

So, there is much agreement on health human resource planning as a key issue and some work on trying to bring all of the stakeholders together but many barriers to coordinating HHR planning and the collection of data nationally, particularly on health executives/managers.

4.4 Supply – Is There a "Looming Leadership Crisis"?

Ensuring the right number of health managers/executives with the right competencies, available to lead and administer health services where and when they are needed is complex and influenced by many factors. What is the "right number"? Fooks et al say that the definition of shortage needs to be considered carefully. Part of the problem identifying shortages relates to the lack of a common standard for defining adequate staffing levels.[2] Indicators can include vacancy rates or administrators perceptions of the staffing situation at their institution. Buchan and O-May[35] identify five objective indicators:

- Vacancy rates
- Turnover/wastage rates
- Agency/bank nurse employment
- Overtime/excess hours working
- Unemployment rates

Other factors affecting supply can be changes in the organization of health services delivery, the span of control for health executives and demographics. A survey of 108 Canadian health care CEOs in 2001 found that 31.5% of this group were 55+ years of age, 9.26% over 60; however, slightly over 57% were 45-54 meaning that now they would be 49-58 (if they were still in the system). Only 9% were 35-44 suggesting only a small pool of future leaders. Statistically significant differences between this sample and the membership of CCHSE indicated that the group over 60 might have been underrepresented.[8] The CCHSE report to the Romanow Commission describes "…a significant depletion in the ranks of health service leaders over the past five to seven years", partly due to the merging of organizations and partly because of the aging leadership group moving into retirement.[36] Those participating in the CCHSE Leadership Symposium, however, were not sure there was a crisis. They did say, though, that if there is a leadership crisis the factors driving it are:

- loss of leadership control – increasing public expectations contribute
- cultural issues
- demographics
- micro-management by governments
- a reduction in succession planning. [37]

Most of these factors, other than demographics, relate to the design of the system and the work place.

CIHI reported, in 2002, that the number of health executive members of the CCHSE, 2,308, was down 19.5% from 1993's number of 2,868. All provinces experienced a decrease in the number of members with the largest percentage decrease in PEI (73.5%). Only two provinces experienced less of a decrease than the national ratio, Nova Scotia (2.4%) and Ontario (6.0%). There is considerable variability in the number of CCHSE members over those years.[4] It's impossible to know, from these figures, and because membership in the CCHSE is voluntary, if there was a real drop in numbers of health service executives, due to restructuring or retirements etc., or just a drop in membership, or other factors at play.

Statistics Canada reports on the near-retirement rate (NRR - the percentage of workers who are within 10 years of the median retirement age) saying that "Canada's population is aging and baby boomers are fast approaching their retirement years. If labour force participation by age remains around the present rates more seniors will likely mean a shrinking workforce….In health care and social assistance…the NRR increased from 9% [of the workforce] in 1987 to 25% in 2002." While not specific to health care managers they point to a 29.9% NRR for management in 2002 as compared to 15.5% in 1987.[38] In health care the median retirement age is 61.8. They also say that managerial occupations in general will be the hardest hit by the baby-boomer retirement and that health care is particularly vulnerable because this sector has a higher proportion of managers and professionals with requirements for greater experience and higher levels of education, so both tend to be among the oldest employees.[39] Managers and professionals in education and health care are about five years older than those in other industries with high educational requirements.[40]

4.4.1 Provincial Reports

Some reports from the provinces refer directly to health service executives and some indirectly, but there is very little data on the supply. Complete sector studies have been done in Quebec, Nova Scotia and Newfoundland.

A Quebec commission studying health and social services said that poor morale and departures of many senior employees weakened the health system's expertise and the strength of its work teams resulting in a poor record of attracting new employees. "The issue becomes even more pressing in view of the fact that 50% of senior managers will be reaching retirement age within 5 years, while the number of first-level managers, according to many sources, is already often below the threshold number required to ensure motivating management." The study also says that pay scales, which are less and less competitive, may explain the difficulty the system is having in recruiting and retaining well-trained managers.[9]

A report by the centre for senior health executives in Quebec talks about 6,867 senior executives (72%) having to be recruited during the next 10 years and 80% of middle managers; current average age is 52; 23% of senior executives are 55+. The report points out that the attractiveness of these positions seems to have diminished over the last few years, especially to possible external candidates. Lack of recognition for the work of health executives also has a negative affect on satisfaction in the job and hiring. There is frustration also with high work loads, lack of transparency in decisions, lack of collaboration, difficulty in maintaining a work-life balance, lack of autonomy, lack of technical and human resources to support them in their functions and inadequate remuneration. They also report a lack of succession planning and little consensus on the competencies required.[5]

Newfoundland and Labrador did an extensive study of their health and community system managers with a *Final Report* in 2003. In previous years institutional boards had a supply of about 1040 managers before restructuring in the mid to late 90s and about 660 after, a cut of 37%. In this 2003 study there were approximately 975; in the study 569 surveys were returned with a response rate of 58%. For the purposes of the study a manager was someone who was remunerated on the HAY management pay scale. The results of this study were:

- As of September, 2002 there had been 950 managers working throughout the province; approximately 67% were female; 30% were 40 years old or younger; 50% were over the age of 45.
- 37% had less than 5 years management experience
- 60% were in clinical or program management positions; 29% in administrative or support services positions
- 49% had less than 10 employees reporting to them; 10% had greater than 50 with the majority of those being employed in clinical or program management positions. 64% of those with greater than 50 reporting to them had a nursing professional background.
- The turnover rate was 16% with 150 management separations in 2001/2002; in 53% of these the manager moved to another position within their organization; 69% of the positions posted were filled internally with approximately 3.4 applicants per management posting who met posting requirements.

- Assuming a retirement age of 55 - estimated that 53% would retire in the next 10 years; if 58 used as retirement age, retirement decreases to 39%.
- 95% said they worked some overtime each week; 33% of the senior management said they worked more than 15 hours; while others tended to work 5 – 10 hours more. Managing the workload was reported as the biggest challenge. Travel responsibilities were high with 50% indicating they traveled more than once a week.
- Most were satisfied with their jobs and were likely to remain with their current employer for the next 3 to 5 years and felt that their work was important although they were dissatisfied with their level of compensation, their professional development opportunities and the amount of paperwork required of them. [15]

Nova Scotia in its extensive study of health human resources found there were 1,211 health service managers in 2002; 60% were female and 40% male; average age was 47.[41]

Alberta's report, *Going Further,* includes a brief section on human resources and expanded scope of practice. It makes the statement that shortages of health care personnel are a serious concern for the health sector. While it does not directly refer to health care managers, it identifies a lack of information to underpin labour strategies and "…the absence of a strategic long-term focus for human resource management in the health care sector. Workforce management has been closely tied to funding. People are hired to meet rising demands and then laid off when budgets are tight" leaving "...the health sector with a legacy of morale issues and shortages of skilled workers when funding increases." [33]

In British Columbia data was collected, by the Health Human Resource Unit (HHRU) of the University of BC, established as a demonstration project by the Ministry of Health, from 1983 to 1999 on a biennial basis on health service administrators, and the data appears in the 'Rollcall' series of reports over these years. Data was collected from as many membership groups as was possible in an effort to produce the most accurate count of health service executives in BC, but the numbers reported are probably incomplete. Also, the only data they were ever able to collect was on (employment) location within the province. They were never able to collect other basic health human resources information such as age, sex, type of postion etc. and the data was not very reliable because the numbers were based on voluntary membership in CCHSE and the American College of Health Executives (ACHE).

4.4.2 Interviewees Opinions of a Leadership Crisis

There are conflicting opinions about a leadership crisis in health care among those interviewed. On the one hand it appears to be difficult to attract people of "excellent caliber" to "plum jobs", the number of people who express interest in senior management appears to be down and there are a large number of senior executives who will be retiring; on the other there has been a change in the span of control and where a province might have had 160 hospitals and many other health services, each with CEOs and Vice Presidents, there are now six or nine health authorities and there still appears to be an oversupply of people applying to enter MHA programs. In Quebec the new CEOs are younger, in their 40s, which may create a significant renewal for system. In some places, though, 50% of senior management are 50+ years old (and with the rule of 80 – age plus years of service) eligible to retire now. In Quebec,

Newfoundland and some other provinces there is an issue of perceived low compensation for the caliber that is being expected.

Some thought the quality of applicants for senior positions had decreased and expectations were rising; jobs were larger in scope. The span of control is more demanding and the job is more difficult, more complicated and diverse. People are leaving the system because the pressure is too high and time commitments are very heavy. Also, senior people are not delegating to lower levels and grooming and mentoring people. We also don't do a very good job of evaluation, especially 360 degree evaluation. One thought the "pipeline is drying up" and suggested fast tracking internally and bringing in new people from closely related but non-traditional areas.

One suggested that we could capitalize on the wisdom of those leaders retiring or leaving the system by using them as mentors and coaches and giving them part-time assignments. Executive teams need individual coaches to become cohesive.

There is data in some provinces about the supply of health service executives, some evidence of reduced numbers, no evidence about what the right number might be, and conflicting impressions about the issue, but no convincing national data or evidence that there is a "looming crisis" or shortage.

4.5 Production of Health Service Executives/Managers and Leaders

Much of the literature on leadership comes to us from academic and other articles about business and primarily from the US. But while much has been written about leadership the concept remains elusive. In health care there have been fewer studies and analysis, of what it takes to be a health service executive and leader, and in Canadian health care even fewer but there has been increasing interest. "Perhaps to an extent unprecedented in history healthcare is a human enterprise. Within its dynamic context myriad stakeholders with increasingly diverse perspectives, needs, and agendas, and growing levels of knowledge and vested interest, are involved in unpredictable and uniquely complex situations with uncertain outcomes."[42]

A CHSRF-funded study of Canadian nursing leadership is currently underway (2003-2006). "The overall goal of this three-year study is to profile current nursing leadership and management structures in Canadian hospitals by examining the organizational and structural characteristics of nursing management roles (at senior, middle and unit levels) in teaching and community hospitals." The study will also look at "…how nursing leadership roles in hospitals settings across Canada have changed and the factors that are important in enabling nurse leaders to perform their roles."[43]

The production of health service executives/managers, their training and education, leadership development, coaching and mentoring, even succession planning, assumes we know what the competencies, i.e. knowledge, skills, and attributes are to do the job. In 2001, Pollara surveyed a nationally representative sample of 200 administrators randomly chosen from the Canadian Healthcare Association. Of that sample, 20% strongly agreed that "today's managers are appropriately trained and

experienced to manage health organizations and the healthcare system in general with another 59% somewhat agreeing "…suggesting that many are unsure that the profession is getting the support it needs to cope with the rapidly evolving changes demanded of it." (20% strongly disagreed.) Just 7% strongly agreed "that there will be enough appropriately trained and experienced managers for our future healthcare system. Some 68 % disagree with this statement."[44]

There is a great disparity in level of education at the management level across the provinces. In the survey of 108 Canadian health care CEOs[8] 80% or more of the CEOs responding had received a Masters level designation with 51% having a MHA. A little over 7% had MBAs, almost 3% PhDs and 3.7% MDs. Recommendations include that MHA program content and other healthcare leadership training programs should reflect the perceptions of CEOS in terms of the skills required now and in the future.[8] In the Newfoundland health human resource study 67% indicated their highest level of education was either a Certificate/Diploma (39%) or a Bachelor's degree (34%). 19% held a Master's degree. 3% were MDs. 22% were pursuing further education. 78% believed their education and experience had prepared them for their managerial role. Newfoundland's study recommended that the government and the health boards define minimal competencies for health and community system managers and develop learning plans on how these competencies will be achieved.[15]

A current study on nursing practice in rural and remote Canada will provide rural and remote communities with information about how to better attract, retain and support registered nurses.[45] Some of the objectives of that project might be applied to one on health executives. The following objectives substitute "health executives" for "registered nurses":

- articulate the roles and functions of health executives in rural and remote Canada
- identify what is common and different among health executives' roles and functions in various settings
- show how factors in the health executives work contribute to the development of expertise
- identify needed organizational and policy support and priorities for basic and ongoing education for health executives in rural and remote settings
- contribute to policy and management discussions on the work, recruitment, retention and education of health executives in rural and remote Canada.

The Centre for Education Statistics of Statistics Canada is conducting a study on the production element, i.e. education and training measuring the impact on the supply of new entrants into the health sector and a variety of flows between health education and occupations but there is no indication that this would relate to health care executives.[7]

4.5.1 Competencies Required by Canadian Health Service Executives/ Managers and Leaders

A number of competencies/skills that health care leaders will need in the future have been identified recently in Canadian literature, symposiums and focus groups and there are many variations on a number of themes. In addition concepts of leadership are constantly changing. Current concepts are summarized in the following list of competencies. (In addition there are a myriad number of articles about leadership

in American business literature – too numerous to discuss here – which identify competencies/skills for leaders.) There aren't any studies or literature documenting whether or not health care executives/managers in Canada have these competencies. Baker points out that "a validated set of competencies for a complex field like healthcare leadership is likely to be extensive" and "there are several reasons for why the development of healthcare leadership competencies is likely to be a slow, deliberate process:"

- "Competency models have often been developed for technical fields where there is high consensus on the necessary work tasks and the work processes needed for successful outcomes are well understood. Healthcare leadership is not that simple."
- "Educational and experiential needs of healthcare leaders will vary depending on the stage of their development."
- Health care is a complex field, with the characteristics of complex adaptive systems, and not easily reduced to simple descriptions. The "…the lack of consensus on next steps is one hallmark of a complex adaptive system that is approached with traditional management tools."[46]

Nevertheless, the competencies/skills identified, as needed by health care leaders in recent Canadian literature, symposiums, interviews for this project and previous focus groups are:

- Strong communication skills[8] [47] [48]
  - increased emphasis on public relations[8]
  - Able to create shared values and vision that inspire people to the mission of the organization and to moving the vision forward[11] [39] [49] [50] [51]; also champions solutions for organizational and community challenges and energizes commitment to goals[52]
  - The MacKinnon et al study found listening and verbal communication rated as two of the five most important managerial competencies and found this area as one in which they need improved skills.[48]
  - The top three management activities identified in the Nova Scotia study, as performed during the workday were: communication, human resource management and policy development. 50% said not enough time was devoted to policy development.[41]

- Commitment to the consumer[48]
  - The MacKinnon et al study found commitment to the consumer rated to be one of the five most important competencies.
  - Identify, evaluate and implement strategies and processes, designed to yield effective, efficient and high-quality customer-oriented healthcare.[52]
  - Continuously assess and improve the quality, safety and value of health care[52]
  - Integrating the needs of the individual with those of the community, optimizing opportunities to improve the health of the populations served within the context of the health care environment and policy[52]

- Effective relationship building
  - Working through people to enhance their accomplishment[42]

- The MacKinnon et al study found teaching and mentoring for staff to be rated as less important.[48]
- Empowering broad-based action[49]
- Develop and foster change agents to achieve the vision[49]

o Ability to share leadership; fostering teamwork and collaboration[8]
- The MacKinnon et al study found teambuilding rated to be one of the five most important managerial skills[48]

o Ability to build relationships, networks and sustaining alliances[8] [49]
o Develop cooperative relationships and effective information exchanges within the organizations and the broader communities served[52]; stimulate social accountability and community stewardship[52]
o Building good board relationships[8]
o Building good relationships with the public; image building[10]
o Being able to influence people[42]
o Building trust and credibility[49]
- Acting in a manner that reflects and supports integrity[42]
- Generating short-term wins[49]

- Political awareness and sensitivity
  o In the MacKinnon et al study participants found this to be the competency with the largest difference between perceived importance and self-assessment of competency level.[48]
  o Identified by Bolman and Deal, in their research, as the single most important attribute in a CEO's success[53]

- Systems thinking; systems-driven leadership[10]

- Managing change and transition
  o The Mackinnon et al study found flexibility in effectively managing change to be rated among the top five most important managerial competencies.[48]
  o "…successful leadership is linked to successful change management." [54]

- Critical thinking skills
  o Skills of problem-solving, doing research, analytical skills, conceptual thinking and flexibility in thinking, evidence-based decision making were all thought to be important.

- Ability to manage the culture[8]
  o Creating and sustaining inclusive environments
  o Creating an engaging environment
  o Anchoring changes in the culture[49]

- Effective use of resources
  o Being accountable
  o The MacKinnon study found efficient and effective management of assigned assets to promote optimal utilization of resources to be rated as less important.[48]

- Ability to manage themselves[11]
  - Balancing home and work life was suggested as needing to be added to the CCHSE competencies by respondents in the MacKinnon et al study and stress management was an area in which they needed to improve their skills.[48]

Attributes required are:

- Creativity[8 51]
  - We need different mind-sets – you have a crisis if you don't have creative, not linear thinkers.[50]
- Understanding of their leadership models and styles and their own personal leadership style and how to use it
- Emotional intelligence and the ability to assess it[48]
- Personal humility and professional will
- Ethical and values perspective[52]
- Commitment to personal and institutional development[52]

4.5.2 Health Care Leadership Development in Canada

There are many ways to develop leaders but formal training seems to have been the primary vehicle for developing leaders in Canada, along with executive programs. There are a number of Canadian universities offering Masters in Health Administration, Masters in Business Administration and other formal degrees and executive programs which health care executives/managers take to increase their knowledge. Some argue that the graduate education model is inappropriate for developing healthcare leaders, that "cognitive understanding is a small part of leadership development" and that what is required "…is a practitioner-based learning model that focuses on developing emotional intelligence. As illustrated by the success of the Centre for Creative Leadership, such a learning process involves experiential learning with and from peers in a supportive environment …. Future leaders must be provided with opportunities to reflect upon and refine their emotional responses to situations that call for leadership." Mentoring is also a powerful tool for learning leadership.[55]

Leatt and Porter [56] note that corporations have written off the ability of MBA programs to prepare future corporate leaders. Instead promising people are targeted for internal corporate development programs, and a large number of corporations, and recently large health authorities, sponsor their own external executive development programs that are specifically tailored for their organization. They also argue that, because there was little investment in executive development in hospitals and health organizations graduate programs in health care management provided a foundation for future leaders in health care.

Stefl proposes using the Dreyfus model, applied to the development of competencies in nursing, which suggests there are five stages for skill development: novice, advanced beginner, competent, proficient and expert. A novice manager would rely on the rules or policies applying to a situation; a more experienced manager would respond intuitively drawing on experience and values, having internalized the rules and their accumulated knowledge of how to apply them (or not) to the situation. She suggests that

"…the development of expert (and perhaps even competent and proficient) leaders is beyond the scope of academic programs. It must occur through on-the-job experience coupled with continuous learning activities" and some type of disciplined reflection.[57]

Leatt and Porter propose a "new model for developing healthcare leaders":[56]

1. Move "from a degree and then CEO-for-life model to a lifelong learning model. Skills development requires continuous practice.
2. Recognize that there are five pivotal stages of educational intervention
   i. Graduate education
   ii. Management training (through fellowships, field experiences, etc)
   iii. 360-degree assessment feedback and coaching
   iv. Formal mentoring
   v. Intense leadership experience
3. Leadership development at all these stages needs to be competency based.
4. And assessment oriented – self-awareness is key to being an effective leader – development of a leadership development plan needs to start early.
5. Framework for leadership development needs to be based on: individual leadership knowledge and skills, organizational improvement and strategic positioning of the organization.
6. Need to adopt the principles of adult education – that all education is reflective, interactive and participative.
7. Skill development should be done within a framework of quality improvement.
8. Development should be interdisciplinary.
9. Need to continuously develop team participation and team leadership skills.
10. Leadership development should be considered as a smart investment.

Conger and Benjamin, [58] in the US, suggest that there are three types of focus in leadership development:

- Individual skills development
- Socialization of corporate values and vision
- Promotion of dialogue and implementation of a collective vision.

They suggest that we still have a long way to go "…to reliably produce leaders who can cope with and, more importantly shape the future. The risk is that tough times or competing demands will lead companies to believe that other needs are more important and that leadership development should be tabled until difficulties subside."

A cautionary note, about moving into sophisticated leadership development, is sounded by Wong and Modrow. They find there are limiting factors in the current health care environment. The complex network of stakeholders in the healthcare system "…might potentially offset the benefits of a leadership program. Within the Canadian healthcare system, the factors that could limit the effectiveness of a leadership development program include the following:"

- Various interest groups are reluctant to relinquish power so it is difficult to lead effectively
- Unclear delineation of areas of accountability

- Use of market principles that promote lack of trust
- Interference between performance and accountability
- Changing definition of performance measures.[59]

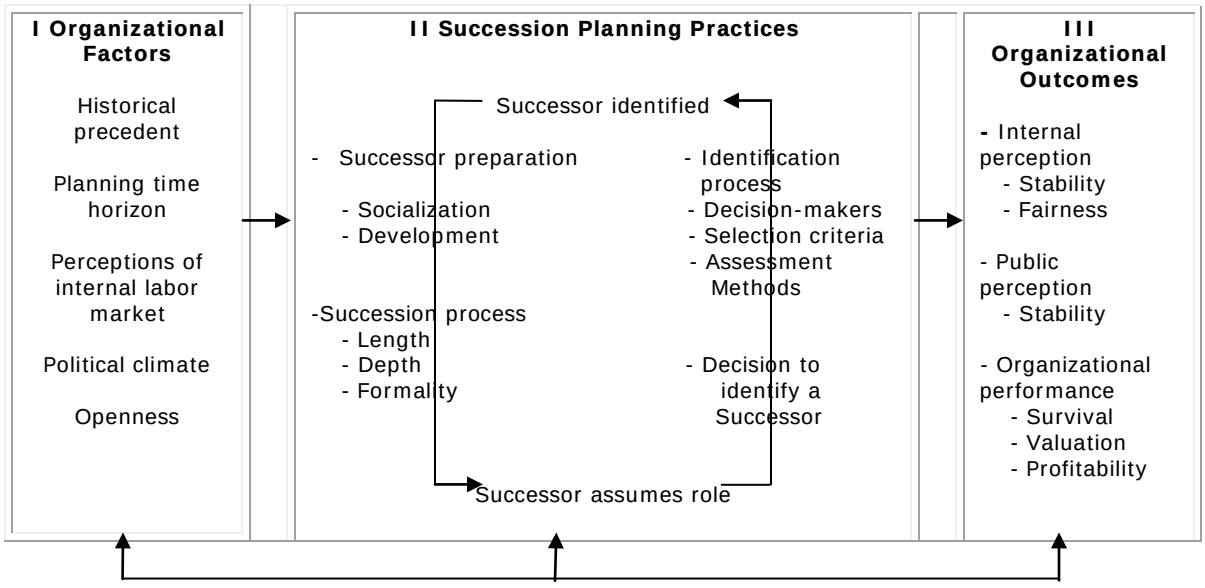
Ready and Conger add that leadership development efforts often fail because they are not aligned with strategic goals and frequently are seen as quick fixes. Executives become focused on the leadership development products rather than on the problems to be solved.[60]

4.5.3 Succession Planning

An American report on CEO succession planning in hospitals uses an operational definition: "…a structured process involving the identification and preparation of a successor; for a given organizational role, that occurs while that role is still filled."[61] This report "…divides succession research into three domains: organizational factors affecting succession process, practices (the succession process itself), and outcomes associated with each. Figure 1 shows an integrated model of the succession planning process which Garman and Tyler constructed to frame the research.

Figure 1

An integrated model of the succession planning process



In their literature review, Garman and Tyler found that the organizational environment significantly influenced the succession planning process with succession planning most likely to take the form of prior approaches.[61 62 63] They also found, that although succession practices varied, and could be formal or informal, there was a common underlying structure, moving from identifying the successor to the successor assuming the role and back again. Multi-organization evaluation studies of succession outcomes, though relatively uncommon, have yielded some important findings: hiring someone externally is often interpreted as the incumbent performing below expectations and/or fundamental differences between the executive leadership and the board.

From their review of evaluation studies and supplemented with more informal articles, Garman and Tyler developed a preliminary set of "best practice" guidelines:

- The executives and board must dedicate time and hold one another accountable for the process.
- Early identification of talent – orchestrate significant developmental cross-functional assignments at a time when major shifts in job responsibility are easier to handle; build feedback loops into the assignments
- Use objective criteria or competencies against which to assess potential candidates
- Benchmark the candidates against one another and also against outside "best" leaders – challenges existing viewpoints
- Measure success – using formative and summative assessments to evolve practices – could include percent of candidate pools selected for key positions; business results achieved

In the survey they conducted of CEOs and board chairs in smaller community hospitals they found that 57% of the responding institutions (397) indicated their current CEO was hired from outside the organization, 28% from within and 15% as part of a planned succession. While only 1% indicated that succession planning was not useful, in 78% of the hospitals succession planning was not routinely done. The most frequently cited reasons for not conducting succession planning were that it was not a high enough priority (46%), the current CEO was too new (31%) and there was not an internal candidate (25%).

Corso says that "a critical aspect of succession planning is ensuring that leadership capabilities are sufficiently developed in individuals identified as having the potential for future ascension to leadership positions." [64] But many Fortune 500 companies don't plan for a successor.[65] Santora says that "all corporate board members and CEOs worth their salt should list CEO succession as one of their top management priorities" People are not "passing the baton" [65]

The most formal succession process used in corporate America is where "…an incumbent CEO works with an heir apparent and passes on the baton of leadership to the heir" commonly called *relay succession*.[66] There are two types of internal succession: relay and non-relay, i.e. no one person is designated as the successor. Zhan and Rajagopalan compare relay succession with nonrelay inside and outside successions. They found that relay succession:

- Facilitates of the power transition – stakeholders have enough time to get to know the person; potentially reduces the turbulence
- Delivers on-the-job training – performance risk due to new CEOs lack of context-specific skills may be reduced
- Signals stability to stakeholders
- Provides insurance should something unexpected happen to the incumbent.

Their research found that if a firm has multiple inside candidates for the CEO position it is less likely to designate one as an heir apparent but tends to wait to select a new CEO. In their comparison of post-

succession firm performance following different types of CEO succession they found the best performance following relay succession and no difference for non-relay inside or outside succession.

Canadian health care organizational experience with formal succession planning appears to be limited. There are a few instances of recommended activity:

- The Human Resources Plan Overview of the BC Ministry of Health Services includes strategies for proactive succession planning and the identification and development of potential leaders.

- A human resources sector study in Newfoundland recommends that health boards develop succession plans for their respective health and community services system managers. It also supports increased use of preceptor programs and the development of a Master in Health System Management at Memorial University.[15]

- The Quebec commission on health and social services recommends, because the majority of Quebec's executive directors will be leaving within 10 years, that the Ministry develop and implement a program aimed at preparing future executive directors with the following characteristics:
  - collaboration of all the executive directors to identify potential candidates, based on a clear set of criteria
  - includes a rigorous process for evaluating potential
  - provides for individualized development programs.

  And in addition, that the working conditions of management staff be "… modified to offer learning opportunities such as continuing education programs, access to assistant director positions, interim positions or practical training periods." They also recommend that mentoring systems be put in place to provide for the transfer of expertise.[9]

A number of those interviewed commented on succession planning:

- In terms of succession planning, we can't take the past situation and extrapolate it into the future. Competition for good people is significant but that experience is off-set by how we make use of existing resources. People in clinical professions are being trained in management. There is a cadre of physician leaders (number of graduates from the Physician Manager Institute) who are moving into CEO slots. There appears to be a gap and may be a crisis at the VP level – those being promoted moving into CEO positions are not rotating through positions to get a broad view of the organization. VPs of Human Resources are not stepping back far enough to look at the potential within organizations. We have to look at transitional strategies – we can't generate managers/leaders overnight.

- People in senior positions are going to be retiring in the next 10 years and they are not mentoring the next level; boards are not bringing in new blood and are often recycling "the old guard".

- We also have to rethink what we mean by succession planning. The days of the 30-year employee are gone. Over the last few years a senior management change has meant that different skill sets are valued. The younger generation is not going to work as the boomer generation or older ones did. They say let me give you five years and then I'm looking.

The CCHSE report to the Romanow Commission says that opportunities to develop succession planning for the senior levels have been reduced with the elimination of many middle management levels and little time to coach and mentor younger leaders. At two recent conferences in BC the Deputy Minister of Health stated that the health system might be undermanaged and they might have cut too many positions.

So we don't know if we are producing the right number of future health executives/managers with the right competencies. We also may not be developing our current managers and planning for succession in the best way possible.

4.6 Management, Organization and Delivery

The quality of working life, how the system is organized and the design of management positions all have an impact on health executives/leaders' ability to do their jobs. A synthesis paper by the CPRN, *Creating High-Quality Health Care Workplaces,* drawing widely on workplace and organizational research, outlines four main components of a high-quality workplace:

- The work environment broadly considered, workplace culture and the human resource practices that shape it.
- Job design and organizational structure (including technology)
- Employment relationships, which covers issues from trust and commitment to communication, leadership
- Industrial relations – relationships among employers, unions and professional associations.[67]

The number of reorganizations in many provinces has created turmoil for a number of years. The CCHSE report to the Romanow Commission identified "…the difficulty of managing what appears to be a 'moving target'" and talks about government interference: "While few governments would interfere with the professional decision-making of physicians or other health care providers, there is little hesitation to direct and frequently contradict the decisions of professional health service executives…. Difficulty in meeting greatly reduced budgets, or implementing often contradictory decisions has resulted in governments making public claims of mismanagement."[36] Examples abound including a recent one in British Columbia with a CEO being fired for public concerns about emergency service in a community. The CCHSE report describes the need to distinguish policy governance from executive governance.

A survey of 108 Canadian health care CEOs' perceptions and experiences of the 1990s organizational and system-wide change indicated that "most CEOs now lead multi-site, multi-facility health organizations or regionalized systems" which vary considerably in size and scope. "The flattening and reduction of senior management structures has meant more work and responsibility for the CEO." Concerns were also identified with deteriorating relationships with physicians and government. The authors recommend that the impact of the health system change on the CEO role should continue to be monitored with regular

leadership surveys.[7] Armstrong et al also found that "reductions at the senior management level have had a great impact on CEOs, dramatically changing organizational structures, senior management roles, and the scope and burden of work for the CEO….There may be signals in the survey data that the reduction was too severe to be sustainable over the long term."[8]

The Armstrong et al study also found that respondents mentioned most frequently the shift in their boards from a management/operational focus to a policy/governance focus; however, boards were also more political both in terms of their relationship to government and their communities. CEOs' experience of their changing relationship with government was almost exclusively negative, although data may have been skewed because of a high proportion of respondents being from Ontario. They indicated that there was more and more micro management by government and difficulties some governments had in devolving responsibilities to regional health authorities. More of the CEO's time was spent on lobbying activities, keeping aware of changes and responding to demands for more accountability and outcome measures. Also forging alliances and for-profit partnerships has been an area of dynamic change and dealing with the integration or networking of different corporate cultures within large health authorities.[8]

A study of predictors of nurse managers' health in Canadian restructured health settings found that lack of necessary information, resources and support to perform their role effectively put nurse managers at risk for developing emotional exhaustion, at the heart of burnout. "The level of managers' emotional exhaustion in this study was higher than in previous studies….The high emotional exhaustion levels may reflect the impact of hospital restructuring over the past decade, which resulted in increased span of control, financial constraints, constant changes, limited time and lack of nurses to fill vacancies." The findings also suggest "that having flexibility in their jobs as well as the ability to exercise creativity and discretionary decision-making make managers less susceptible to burnout." Developing communication and information channels with colleagues, subordinates and supervisors as well as access to opportunities to learn and grow are also important. Lack of autonomy or control over work was the factor most strongly related to emotional exhaustion. [68] (The CCHSE Leadership Symposium mentions this too.)

Quebec's commission agrees saying that in the current state of affairs health executives "…find themselves practically divested of the executive powers which are considered indispensable in large service-oriented organizations. In most strategic areas of management, standards and directives dictate what can be done and how to do it….Can an executive director be expected to have the ambition to reduce the deficit of his institution when the staff, physicians and even his own board of directors will only reproach him for it?" The difficulty in filling managerial positions in Quebec, the commission says, can be partly explained by the "…culture of confrontation and centralization that has characterized management as well as union-management relations in the public sector since the 1970s. Unlike other sectors the health system has not recognized the strategic importance of its human resources and the development of stimulating work environments to retain the best people. The health system also doesn't "…take into account the foremost principles of management….The diversity and the complexity of situations [health executives] face every day require that they be allowed a great deal of autonomy…."[9]

The commission also comments on the fractured nature of management organizations in Quebec with one for executive directors, one for senior managers and one for middle-level managers. "All of thee organizations…are also deeply involved in the affairs of the [health system] and often intervene between

the official levels of governance. In addition, they often act as quasi-decision-making bodies…rather than as associations serving their members." It would be more desirable, the commission says, for these groups to adopt a partnership approach.[9]

The Quebec Commission and others have commented on the turnover in Deputy Ministers of Health and other Ministry of Health positions which exacerbates the working climate for managers. In Quebec in 10 years six different people held the position of Deputy Minister and there were 22 different assistant deputy ministers. "It is not by chance that the Institute for Research on Public Policy recommended to Canada's first ministers…that they promote more stability among the management teams in their departments of health."[8] Rapid turnover in these positions occurs in other provinces also.

In the Nova Scotia health human resource study the quality of work life in health care organizations was thought to be a significant factor in recruiting and retaining people. "Health care workers are increasingly thought to value a more balanced lifestyle, including more time to spend with their families…. Health service managers suggested that the impact of personal lifestyle sacrifices, increasing levels of stress, burnout and long working hours of health care leaders may be a potential disincentive to attracting future leaders into management positions. The study reports that, in 2000, health care managers took 60% of their allowable vacation time.[41]

A paper comparing US (1968 to 1993) and Canadian (1971 to 1986) hospitals, using national medical care employment data from both countries, analyzed health administration costs and found that Canada employed more clinical staff per million population. In 1986, the US deployed 2,137 more health care equivalent personnel (with one FTE being 2000 work hours per year) per million population than Canada and this excess was all administrative. The researchers' conclusions were that if US hospitals and outpatient facilities adopted Canada's staffing patterns there would be 1,407,000 fewer managers and clerks doing paperwork in the US system. They also say their figures understate US administration. "The US/Canada divergence – and the low administrative costs reported for globally budgeted hospitals in the United Kingdom, Sweden, France, and the United States …implicates the fragmentation of multi-payer systems as one cause of high administrative costs." [69] With much restructuring in Canada's health care system taking place since 1986, it may be safe to say, that there are even fewer health administrative personnel. What we don't know, and what the report doesn't say is, given the increasing complexity and demands for accountability, what is an appropriate number for health executives/managers to be able to fulfill their functions without working such stressful, long hours and sacrificing their personal lives.

A international study done in 1991 on defining excellence in health service management, with 93 health service executives in 14 successful hospitals in the US, Canada and the UK, found eight factors of success for hospitals which still seem relevant today:

1. Emphasis on formal corporate and strategic planning processes
2. Willingness to embrace and improve quality
3. A belief that people management is critical – through the development of effective human resource management policies and procedures, information systems, effective training programs, change management programs and remuneration and benefit programs

4. A commitment to organizational flexibility and improved organizational climate: welcoming change
5. Acceptance of the need for delegated budgetary responsibility especially to clinicians, and the convergence of the medical and managerial interests
6. An uncompromising attitude to improving information systems.
7. A belief that competition between hospitals can lead to efficiency.
8. A focus on continuously reducing costs and improving productivity[70]

"With human resources shortages becoming increasingly common across the country, a consensus is emerging that a high quality work environment is at least as important as financial incentives to attracting and retaining motivated and productive health care workers." Span of control and autonomy, professional development opportunities, number of overtime hours are all considered to be important.[15] The research from diverse perspectives suggests that skill use, work design and learning are connected. Learning must be built into the design of the work itself. [71]

5. WHAT DON'T WE KNOW: GAPS IN EXISTING DATA

There are many gaps in existing data/information about health executives/managers in the Canadian health care system particularly in the areas of supply and production. Preliminary work before data collection will be to get consensus on a national definition of what a health care executive/manager is and does and figure out whether the existing coding can be used or if new definitions and/or codes are needed.

5.1 Models for Health Human Resource Planning

- What model for forecasting and data collection will help us project future needs?

5.2 Gaps in Supply Data

A few provinces have gathered data on these areas but there is no aggregated national data.

What we don't know or have:

- How many health care executives/managers work in the health system in Canada?
  (We have some data through the National Occupational Classifications but it is impossible to determine a number from current data collection. There were almost 40,000 in the two NOC categories of managers and head nurses/supervisors in 2001. But the other categories have a mixed group of titles, including others not in health care. Restructuring since 2001 has changed many management titles and reduced numbers. In addition unless we have agreed upon definitions we don't know what should be included, for example: Is an assistant head nurse in the NOC 3151 a health manager?)

- How many we will need in the future
- How many will be retiring in 5 years; 10 years

- What is common and different among health executive roles and functions in various settings
- Has restructuring really changed the need for numbers of managers?
- What are optimal numbers?
- Do we really have a shortage?
- Common measurement tools to be able to analyze workforce needs

5.3 Gaps in Production Data

- Trends in hiring new Canadian health executives/managers
- Key competencies that Canadian health executive/managers must have
- Which degrees are desired? Which have proven to provide the best background, are the most successful?
- What leadership development is occurring now in health authorities, health organizations?
- What recruitment and retention strategies work for this sector?

5.4 Gaps in Data about Design of Management, Organization and Delivery

- What types of organizational design of health organizations occur across the country and what impact do they have on numbers and types of managers? For example: does program management require more clinical managers, fewer managers, etc?

6. BARRIERS TO CONDUCTING A FULL STUDY

There are many barriers to conducting a full study:

Data challenges

- Incomplete and inconsistent data and no commitment to a common standard or common data gathering system. A number of limited datasets are being maintained, not linked and are usually designed for a purpose other than planning. CIHI process to access data difficult. Planning methodologies are not well developed in Canada.[25] If collecting data from health organizations they have multiple HR software systems.

- Finding data – registering and regulating the profession - going to need primary data collection (except for those provinces which have information)

- The following data issues come from the Nova Scotia study[41]:

    - "There is no nationally recognized set of data elements for HHR planning for health professionals. National organizations like CIHI are working to address data issues in HHR planning, but they are dependent on the accuracy of input from the provinces."

    - Confidentiality is a key issue

- Individual and aggregate reporting is an issue

- "Quantitative data received from regulatory bodies and professional associations, educational institutions and employers varied in content and format, relative to their data elements, definitions, time frames, and format. These organizations have varying data requirements and resources based upon their mandates and interests."

- Challenging to collect comprehensive supply data for non-regulated occupations; even though Nova Scotia distributed a standardized data indicator template, the quality of the supply data varied considerably.

- Education and training information on funding programs, students, enrolments, faculty was not available from a central source

Other challenges:

- Complexity often defeats a comprehensive approach – different level of standards; different visions; poor communication

- Accountabilities in health human resources are diffuse and there is no coordinating mechanism to pull them together

- Lack of political will to build appropriate national information systems

- Provincial/Territorial support and active participation to a federally funded initiative on a provincial jurisdiction matter.

- CIHI says policy levers (education and training, pricing for services, location of services, types of services, regulation of services) are in multiple hands with a large amount of goodwill required and voluntary cooperation even within a profession.

- "Models for forecasting and data collection have improved over time but rely largely on counting the numbers of personnel relative to a given population and projecting forward to calculate future needs. This has been identified as the least optimal method for planning."[1]

7. POSSIBLE OPPORTUNITIES

There are also some opportunities, other national health human resource initiatives, that may assist research on health executives/managers or that the CCHSE and others may lobby to be part of:

- Funding earmarked for national coordination and planning. How can the CCHSE and others take advantage of this funding and/or lobby to be part of any national projects?

- Linkage of health human resource planning to system design issues in the advisory structure of the Conference of Deputy Ministers. What opportunities might there be to include the impact of system design issues on recruitment and retention of health service executives/managers?

- Priority setting exercise by national health service research organizations has identified health human resource planning as the number one research priority. What activities or applications for research funding grants could be developed for research on health executives/managers to take advantage of this priority?

- Substantial investments in health human resource modeling and policy research – stronger and larger research community interested in linking with decision makers to support evidence-based policy. How can we ensure that health executives/managers are included?

- Pan Canadian Health Human Resources Strategy. How do we take advantage of this initiative?

8. QUESTIONS AND KEY ISSUES

There are a number of key questions and issues for discussion at the CCHSE workshop of stakeholders:

I Definition

1. How do we make sure the definition and study will reflect different structures in a way that serves both provincial and national interests?

II Key Human Resource Issues

2. Critical competencies for leading/managing health care organizations

2.1 What are the critical competencies (e.g. skills, knowledge, abilities, attitudes, values) that health care executives currently exhibit to allow them to move through, or across, the health care system? What are the competencies that we are not seeing now but will be needed in the future?

3. Recruitment and retention

3.1 What could we do to increase the attractiveness of the environment for health care executives/managers?

3.2 What has been our experience in terms of succession planning? Is there a cohort of people who are being exposed to different management/leadership levels and moving across operational functions and facilities? What about the use of mentoring, coaching? What about professional development?

3.3 Is there a shortage of health executives/managers or leaders within our organizations and/or in terms of the number of interested/qualified individuals available externally?

III Methodology for a Sector Study

4.1. Is a Pan Canadian study feasible given the barriers? Can we reconcile the differences? If so, how?

4.2 How can we link a new Pan Canadian study with current studies such as those on physicians and nurses and previous studies?

4.3 How do we take advantage of existing and other opportunities related to health human resource planning and research?

IV So What's Next?

5.1 How do we get partnership (stakeholders, provincial/territorial governments) buy-in?

5.2 Communication/marketing plan?

9. CONCLUSION

There are a number of questions and key issues to discuss around human resources and skill needs of Canada's health executive/management sector. Existing information on the supply and production of leadership and management in the health care sector is sparse and inconclusive. Despite numerous reports about human resource planning for health professionals, health executives have only recently been included in the discussions and activity has been slow to get started. The current organization and environment of the health care work place appears to be problematic for the recruitment and retention of leaders. Despite the data and other challenges to conducting a full sector study there are some opportunities that might assist the industry to find some answers.

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