Health Care Leaders and Managers in Canada: Analysis of the Human Resource Issues and Information Gaps

Discussion Report

Prepared by
Christine Da Prat
Association Strategy Group
February 14th, 2006

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

TABLE OF CONTENTS

Executive Summary

Human resource planning has been identified as a priority in the last five years for the health care sector. In response, governments and the health care community including health researchers have commissioned a number of studies examining the issues. These studies explore the key human resource issues facing the profession. Unfortunately, the health care leader/manager has not been part of these studies although there is a need for a national sector study of health care leaders/managers given the number of key human resource issues and skill needs facing the profession.

Responding to this need, the Canadian College of Health Services Executives (CCHSE), the Academy of Canadian Executive Nurses (ACEN) and the Canadian Society of Physician Executives (CSPE) sought funding support from HRSDC to explore the feasibility of conducting a national human resource study of the health care leadership/management sector. The Leadership Advisory Committee (LAC) comprised of representatives of the sector was formed to guide the activities undertaken in exploring the feasibility of conducting a national study. A number of these activities were completed in 2005 and since then, the Committee recommended the development of a synthesis report to summarize the work completed within the last year into one overall report focusing specifically on the information/data gaps.

Four documents resulting from the previous work completed for LAC were reviewed to prepare the synthesis report. Information from these reports resulted in the proposal of a definition of the health care leadership/management sector for the purposes of conducting a national human resource study of the sector. Key human resource issues summarized according to the themes outlined in the Health Human Resource Conceptual Framework developed by O'Brien-Pallas, Tomblin Murphy, Bauman, and Birch are identified in the synthesis report. Research and information gaps are also included in the analysis of these issues. The primary gap for any national human resource study of the health care leadership/management sector to consider is the availability of consistent and complete data for the sector. This is certainly not the case for the health care leadership/management sector. Incomplete and inconsistent data is a major issue for the sector. There is a lack of commitment to a common standard or common data gathering system and while efforts are underway to address data issues in health human resource planning, national organizations like CIHI rely on the accuracy of input from the provinces and territories. Data may be available in some provinces, but whether or not it is comparable is questionable.

One of the reasons for the lack of reliable data is the fact that this is not a regulated sector. The collection and reporting of any data available varies in content, format, data elements, definitions and time frames. Furthermore, data collected by organizations typically conforms to that organization's mandate and interests. Primary and basic data (e.g., number of health care leaders/managers) will need to be collected to address some of the fundamental research questions raised in human resource planning.

There are a number of opportunities for the health care leadership/management sector to commence work studying its human resource issues in Canada. The health care leadership/management sector can explore collaboration with federal and provincial/territorial governments given this stakeholder groups' recognition of the priority around health human resource planning. Partnerships with health research organizations and other interested health stakeholder groups can also be forged given the current urgency in producing credible human resource data for health care. Awareness of the research challenges provides an opportunity for the sector to address these in developing the framework for a national human resource study. Lessons learned and results from other health human resource studies already completed can assist the sector in moving forward with such a study. A national sector study offers the health care leadership/management sector the opportunity to find some answers to the number of questions raised.

1.0 Introduction

Human resource planning has been identified as a priority in the last five years not only in the health care sector but also, in other Canadian industries. Part of this has stemmed from the considerable re-structuring and cutbacks that Canadians have witnessed particularly in the health care system and part of this has resulted from the shortages perceived in a number of health care professions. In response, governments and the health care community including health researchers have commissioned a number of studies examining the issues. Most recently, Human Resources and Skills Development Canada (HRSDC) working together with Health Canada and the stakeholder community funded national studies of the home care sector, nurses, physicians, and oral health care. Work is underway for the pharmacists profession and proposals are being considered for other health related sectors and professions.

These studies explore the key human resource issues facing the profession. Represented by broad stakeholder groups, the health care leader/manager has not been part of these studies. Indeed a recent situational analysis completed for the Leadership Advisory Committee and by Romilly (2005) concluded that there have been very limited if any, national research human resource projects completed for health care leaders. Much of the literature on leadership is about business and is primarily from the United States. There have been few studies and analysis of health care leaders/managers in general, and fewer still in Canadian health care. Only recently have health executives been included in the discussions and activities underway. Quebec, Nova Scotia and Newfoundland are the only three provinces who have completed sector studies on health care executives. Table 1 outlines the initiatives or reports principally focusing on the health executive/management sector and that Romilly summarized.

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	**Health Canada Pan Canadian Health Human Resources Planning-** Health Canada is working with the provinces, territories, and key	*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	***Centre de Référence des Directeurs Généraux et des Cadres*** –conducted a study, published in November, 2001, on

Domain	Activity		
	National/Federal	**Provinces/ Territories**	**Associations/ Research Groups**
Executives) (includes Succession Planning)	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.	create a demographic profile of health and community system managers and identify key issues facing this group. **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. **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. **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	health and social service executives/manage-ment requirements in Quebec which looks at the period from 2000 with planning to 2010. *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." CCHSE working with 30 national healthcare organizations to develop a more coordinated approach to the national HHR effort. 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.

Domain	Activity		
	National/Federal	**Provinces/ Territories**	**Associations/ Research Groups**
		and strengthening the accountability of senior administrators. Recommends that the Ministry develop a program aimed at preparing future executive directors.	
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. 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.	*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. *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.
Production	*The Changing Role of Canadian Health care CEOs: Results of a National Survey*, 2001 – covered career preparation, skills and attributes, past present	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	**The Executive Training for Research Application (EXTRA) program** Partnership of CHSRF and CCHSE

Domain	Activity		
	National/Federal	**Provinces/ Territories**	**Associations/ Research Groups**
	and future (108 CEOs participated) – survey sample small, limiting applicability but results are suggestive – also covers aspects of other domains.	executives	– 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. CCHSE has initiated a $1M fundraising campaign to endow a new Canadian Centre for Health System Leadership. CCHSE working with many partners to expand leadership training opportunities for health executives.
Mgmt/ Orgn and Delivery of Services			CCHSE's Health System Update on all of the provinces has a section on governance and management CCHSE and others are exploring development of a preferred employer/employee of choice program for Canada.

Source: Romilly, L. (2005). Development of a comprehensive situational analysis of human resources and skill needs of Canada's health executive/management sector. Prepared for the Canadian College of Health

Romilly's report concluded that there is a need for a national sector study of health care leaders/managers given the number of key human resource issues and skill needs facing the profession. Responding to this need, the Canadian College of Health Services Executives (CCHSE), the Academy of Canadian Executive Nurses (ACEN) and the Canadian Society of Physician Executives (CSPE) sought funding support from HRSDC to explore the feasibility of conducting a national human resource study of the health care leadership/management sector.

The Leadership Advisory Committee (LAC) comprised of representatives of the sector was formed to guide the activities undertaken in exploring the feasibility of conducting a national study. These activities included defining the health care leadership/management sector, identifying the information and data gaps, proposing a governance model to manage and oversee a national sector study and identifying a potential list of steering committee members for a full sector study. The Committee also recommended the development of this report to summarize the work completed within the last year into one overall report focusing specifically on the information/data gaps.

1.1 Objectives

The overall goal of the assignment is to provide a synthesis of outcomes resulting from extensive consultations and work completed with the Advisory Committee and Task Force in planning a *Comprehensive Strategic Health Human Resources Study of Leaders and Managers in Canada.* The overall goal of the assignment will be met through the following objectives:

- identification of the information gaps that exist in the health leadership and management sector specifically referring to previous documents prepared for LAC; and,
- summarize conclusions identified in previous documents and reports toward undertaking a comprehensive human resource study of the sector.

1.2 Approach

Four documents were reviewed to prepare this report. These were products resulting from previous work completed by LAC and included:

- Situational analysis report prepared by Lorna Romilly;

- Summary report National Stakeholders' workshop: Human resource needs of Canada's health leadership and management sector;
- Report on National Task Force Meeting, June, 2005; and,
- Canadian Health Care Leadership and Management Sector Definition Study prepared by Lynn Curry.

The first draft of this report was reviewed by LAC in a teleconference. Revisions were incorporated and reviewed in the second draft leading to the completion of the *Synthesis of the Human Resource Issues and Gaps for Health Care Leaders/Managers – Discussion Report*.

2.0 Sector Definition

How the leadership and management sub-sector of the health care sector is defined is essential to scope the parameters for the research framework of a sector study. Although there are several definitions of the sub-sector including those utilized by Statistics Canada and the federal government (i.e., the National Occupational Classification), a detailed review of definitions and consultation with health leaders and managers across Canada was undertaken. A Theoretic Modeling Exercise that included a survey of 56 identified experts across Canada, representing a response rate of 71% (79 surveys were distributed) was completed. Results from the two round exercise were reviewed by LAC who proposed the final definition of the health care leadership and management sub-sector for the purposes of a health human resource study.

To start, a health care leader/manager is *an individual who creates vision and goals and mobilizes and manages resources to produce a service, change or product consistent with the vision and goals*.[1] This individual includes supervisors, managers, and senior administrators and can be employed in a[2]:

- publicly funded health care delivery systems: acute care, primary care, chronic care, rehabilitation;
- health promotion, health maintenance organizations;
- health care services using a non-western traditional medicine paradigm;

[1] Summary report National Stakeholders's Workshop: Human resource needs of Canada's health leadership and management sector, March 23 – 24, 2005, p. 3.
[2] Canadian Health Care Leadership and Management Sector Definition Study: Final Results of Decision Theoretic Modeling Exercise and Recommendations, prepared for the Advisory Committee by Lynn Curry, Ph.D., December 5, 2005, p. 3.

- academic institutions (senior position from each of the health related disciplines)
- associations, foundations or other non-governmental organizations;
- government sections and agencies responsible for health;
- funding agencies; and,
- private, not-for-profit, health care delivery systems.

The health care leader/manager includes a certified health care manager (i.e., accredited by the Canadian College of Health Service Executives) and others who are responsible for a variety of functions[3]:

- provide direct supervision to others who provide care;
- provide clinical consulting to those providing direct care;
- assume role of program managers or department/division heads for units that provide direct care;
- provide administrative, operations or process consulting to department/division heads for units that provide direct care;
- provide direct supervision to those who provide services, resources, products, devices relied upon by direct care providers (i.e., information technology (it), human resources, cleaning);
- assume role of program managers or department/division heads for units that provide services, resources, products, devices relied upon by direct care providers (i.e., information technology (it), human resources, cleaning);
- provide administrative, operations or process consulting to department/division heads for units that provide services, resources, products, devices relied upon by direct care providers (i.e., information technology (it), human resources, cleaning);
- work on the senior administrative team in institutions that provide direct care;
- provide administrative, operations or process consulting to those who work on the senior administrative team in institutions that provide direct care;
- chair boards at institutions that provide direct care;
- participate as board members for institutions that provide direct care;
- provide strategic consulting to chairs, boards and senior management teams in institutions that provide direct care;
- work at senior levels of government with responsibility for any aspect of health care;

[3] Ibid, p.3.

- advise government on health care matters; and,
- work as senior staff in administrative or leadership roles for any agency, organization, association, foundation, non-governmental organization charged with studying or supporting any aspect of the health care system.

The role of assuming the chair of a board or participating as a board member will need to be further defined to identify the skills and competencies required to perform in this capacity.

In identifying the type of role the health care leader and manager assumes, the survey of 56 leaders across Canada and subsequently LAC identified a number of roles that will not be part of the definition of health care leader manager. Appendix A lists these roles. The exclusion of these roles from the health care leader and manager definition does not diminish their importance. Rather limitations pertaining to the role of the health care leader/manager are necessary to ensure sufficient resources and to focus the research.

This definition of the health care leader and manager is somewhat consistent with the National Occupational Classification (NOC)[4] that is used by Statistics Canada to collect labour force and census data. The NOC includes the health care leader and manager in five occupational categories: 0014, 0411, 0311, 3151 and 4165. Appendix B describes the definition for each of the five categories. Although health care leaders/managers are included in these five categories, other titles/occupations which are not in health care are also included. The key limitation between the differences of the two definitions is the ability to use data from Statistics Canada or other research organizations that use the NOC to define occupations. If the NOC definitions are not used, other sources that utilize a more similar definition of health care leaders/managers will need to be explored or the necessary data will need to be collected through a comprehensive survey, the latter of which can be costly.

3.0 Human Resource Issues

The work commissioned in the Romilly report sought to undertake a situational analysis to:

[4] National Occupational Classification (NOC): The National Occupational Classification (NOC) is a system for describing the occupations of Canadians. It gives statisticians, labour market analysts, career counselors, employers and individual job seekers a standardized way of describing and understanding the nature of work. The system includes a series of publications that help these people to organize and use statistics and other labour market facts.

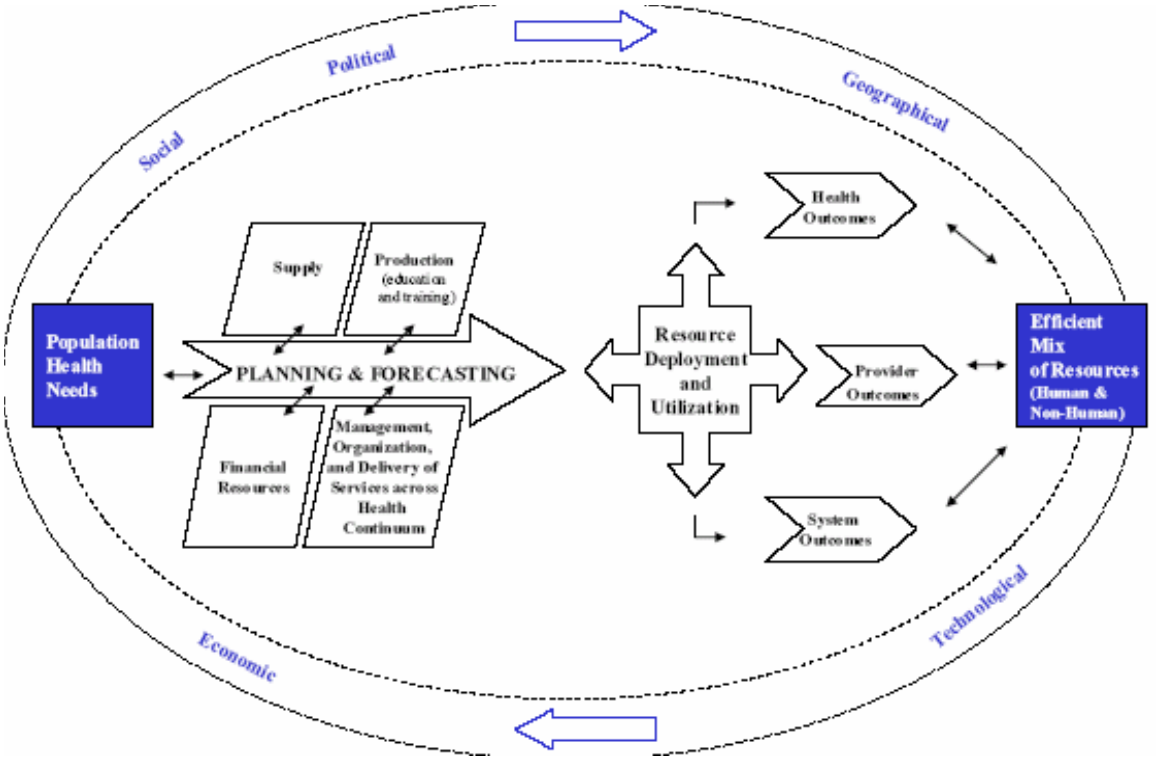
- Identify key data and information requirements;
- Collect and review existing information on leadership and management in the health care sector; and,
- Identify and explore the barriers/opportunities that would affect the feasibility of conducting a human resource study of the Canadian health leadership/management sector.[5]

The analysis used the Health Human Resources Conceptual Framework developed by O'Brien-Pallas, Tomblin Murphy, Bauman, and Birch to guide the collection of the data and information. Available information and data was collected on supply and production of health executives. A search for data around management, organization and delivery of services and the relationship of these to the supply was also carried out. Human resource planning and forecasting was included in the research with the exception of financial resources. Data and information was not collected for the latter component of the Framework. Figure 1 depicts the Framework.

The HHR Conceptual Framework illustrates a number of factors and the environment within which HR planning takes place. The Framework is being used by a number of research organizations including Statistics Canada and the Canadian Institute for Health Information (CIHI). *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada* report also utilized this Framework to guide the overall research work completed for this national study.

[5] Romilly, L. (2005). *Development of a comprehensive situational analysis of human resources and skill needs of Canada's health executive/management sector*. Prepared 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 and Skills Development Canada, p. 1.

Figure 1
Health Human Resources Conceptual Framework



Source: Building the Future: An integrated strategy for nursing human resources in Canada, Research Synthesis report, 2005.

In keeping with the HHR Conceptual Framework, data and information for this report is discussed according to the following themes in the situational analysis report: health human resource planning and forecasting; supply of health leaders/managers; production; and, management, organization and delivery of health services across the health continuum and the workplace environment. The following sections outline the issues and gaps in each theme area. Most of the information presented is derived from the situational analysis report that was prepared for LAC in the spring of 2005.

3.1 Health Human Resource Planning and Forecasting

Recently a number of commissions in health care have supported strong integrated health human resource planning. The 2003 First Ministers Accord states undertaking collaborative strategies to:

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

Indeed, 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".[6] Health human resources are also included in the 2004 First Ministers Agreement and 2005 budget.

The environmental scan conducted by the Canadian Policy Research Networks for the Canadian Health Services Research Foundation (CHSRF) concluded that health human resource issues focusing primarily on recruitment and retention, quality of the workplace and planning models have been identified by all stakeholder groups as a priority for research. That same environmental scan identified "redressing shortages" for nurses, physicians and health administrators as a priority for teaching hospitals and regional health authorities.

Although health human resource planning has been identified as a key priority for stakeholder groups in the health care system, it still remains complex and challenging. Planning at both the provincial/territorial and national levels is complicated by the number of people, groups and organizations involved. Typically health workforce planning has been occupation/discipline specific resulting in a duplication of effort, competition, lack of coordination, revisiting the same issue, and sometimes confusing due to the number of health occupations prevalent in the system.

Traditional forecasting of health care providers has tended to focus on physicians and most recently, nurses. Although a number of forecasting models have been employed, these have varied and have tended to be narrow in focus and scope. Planning and modeling methods are broadening to incorporate more variables and also include system factors.[7] Minimum data sets to support work force planning are being proposed rather than specific forecasting models as is evidenced in a recent initiative from Health Canada. Health Canada initiated a project in collaboration with the provinces, territories, key stakeholders and CIHI to establish indicators and data elements for a National Minimum Data Set for Health Human Resources in Canada. The outcomes of this project are designed to provide a common set of information for health human

[6] Ibid, p. 17.
[7] Ibid, p. 18.

resource research overall. Health Canada has also initiated a parallel project contracting with the Statistics Canada's Centre for Education Statistics (CES) to investigate the availability of data to measure the flow of individuals through education and training and into the labour market. Data gaps will also be identified and strategies to address these gaps will be recommended. Health service executives are included in the list of regulated professions considered for this project.

With the exception of the CES project, most of the other initiatives completed or underway examining health human resource planning and forecasting tends to focus on the clinical health professionals and not health leaders/managers.[8] Indeed, health leaders/managers are not specifically mentioned in the federal government's commitment to participate in health human resource planning with interested jurisdictions.

There is agreement across Canada and within the health care sector that health human resource planning is a key issue and will continue to be a priority in the near future. Although work is underway involving collaboration between health care stakeholder groups, there are a number of challenges to planning and collecting reliable data in health care overall. This is especially true for health leaders/managers that only recently are being considered in discussions pertaining to health human resource planning.

3.2 Supply of Health Leaders/Managers

"Ensuring the right number of health leaders/managers with the right competencies, available to lead and administer health services where and when they are needed is complex and influenced by many factors".[9] Identifying and agreeing on the "right number" is the question debated most often within the health care community including within governments. Careful consideration of the definition of "shortage" needs to be understood prior to addressing this question.

There is very little data on the supply of health leaders/managers available while there is variability in results for that information that is available. This is mainly due to different reporting and recording processes followed by the organizations collecting the data. A 2001 report to the Romanow Commission from the CCHSE concluded that there is a "significant depletion" of health service leaders over the past five to seven years. [10] This depletion was mainly

[8] Ibid, p. 18.
[9] Ibid, p. 19.
[10] Ibid, p. 20.

attributed to the merging of organizations and partly to the aging leadership cohort moving into retirement. In 2002, CIHI reported that the number of health executive members of CCHSE was down by 19.5% from 1993 (2,308 members in 2002 as compared to 2,868 in 1993).[11] All provinces also experienced a decrease in the number of members over these years with the largest percentage decrease recorded in Prince Edward Island (73.5%). Because membership to CCHSE is voluntary, it is difficult to attribute the reason for these decreases in memberships since there are a number of variables that can affect the loss.

A Statistics Canada report on the near-retirement age (i.e., the percentage of workers who are within 10 years of the median retirement age) concluded 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".[12]

Statistics Canada's *Workplace and Employee Survey* of 2000 also reported that professionals in education and health care are about five years older than those in other industries with high educational requirements.

Similar results are reported in the few provincial studies that were completed and looked at the supply issue. The studies completed in Quebec, Newfoundland and Labrador, and Alberta point out a number of reasons for the reduction in health leaders/managers all of which relate to recruitment and retention issues. The studies in general reported on the challenges to recruit and retain leaders/managers. The Quebec study attributed the less and less competitive pay scales as a reason for the province's health care systems' challenges in recruiting and retaining well-trained managers.[13]

The same report also revealed that attracting senior health executives in Quebec has diminished over the last few years mainly because of lack of recognition for the work of health executives, frustration 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 senior health executives in their role and inadequate remuneration. Lack of

[11] Ibid, p. 20.
[12] Ibid, p. 20.
[13] Ibid, p. 21.

succession planning and consensus on the competencies required were other factors reported as attributing to the issue of attracting fewer health executives. A study completed in Newfoundland and Labrador also reported dissatisfaction with work load and compensation among senior health executives and with professional development opportunities.[14]

In the situational analysis report, Romilly interviewed a small number of stakeholders who mentioned that professionals are leaving the health system because the pressure is too high and the time commitments are heavy.[15] More managers are required to support the system given the large number of staff reporting to one leader. Some stakeholders interviewed felt that the quality of applicants for senior positions has decreased while the expectations and scope of work have increased. In a 2001 survey conducted by Pollara, only 7% of the 200 administrators sampled from the Canadian Healthcare Association strongly agreed that "there will be enough appropriately trained and experienced managers for [the] future healthcare system.[16] A further 68% strongly disagreed with this statement.

Although not a wealth of information and data exists in examining the supply issues for health leaders/managers specifically, some provincial level and general national studies on leadership highlight critical recruitment and retention issues that are believed to contribute to the "looming leadership issue". Identifying what the right number of health executives/managers is for the health care sector is the first and foremost question to address. The lack of good national data poses a challenge in responding to this issue. The situational analysis does however, identify a number of recruitment and retention issues that should be considered for future research. Understanding the impact of these issues will assist in developing solutions to the overall supply needs of the health leadership/management sector.

3.3 Production of Health Leaders/Managers

The production of health leaders/managers, their training and education, leadership development, coaching and mentoring, and succession planning assumes that the competencies (i.e., knowledge, skills, and attributes) required to do the job are known. Indeed there is much diversity in defining what the minimum competencies for health leaders/managers are across Canada. There is also disparity in the level of education at the management level across Canada.

[14] Ibid, p.22.
[15] Ibid, p.23.
[16] Ibid, p. 24.

In a national survey of 2001 and of 108 Canadian health care CEOs, 80% or more of those responding to the survey indicated they had a Masters level designation.[17] About 51% of those that responded had a Masters in Health Administration (MHA) while slightly over 7% had a Masters in Business Administration (MBA); about 3.7% a Medical Degree (MD) and 3.0% a PhD.[18] In contrast, the Newfoundland and Labrador health human resource study, found that only 19% of those surveyed had a Masters level designation while 3% had a MD. The majority of respondents, 67%, indicated their highest level of education was either a Certificate/Diploma or a Bachelor's degree. One of the recommendations resulting from that study was that the government and the health boards should define the minimal competencies for health and community system managers and develop learning plans on how these competencies would be achieved.

There are a couple of initiatives currently underway in Canada that will look at the level of education in general. One of these studies is on nursing practice in rural and remote Canada. The goal of that project is to provide rural and remote communities with information about how to better attract, retain and support registered nurses. The second initiative is being undertaken by CES of Statistics Canada. This study is on education and training measuring the impact on the supply of new entrants into the health sector and measuring a variety of flows between health education and occupations. A section related to health care executives will be included. Some of the objectives and results from these studies may be applied to health leaders/managers.

CCHSE, recent Canadian literature, symposiums and focus groups have commenced work to identify the competencies and skills that health care leaders will need in the future. Although these vary in themes and are preliminary observations of competencies, they are a start for any further work in this area. These competencies and skills are summarized in table 2. The future needs of the health care system and potential changes, particularly to the design of health organizations, should also be considered as this will impact on the competency requirements of health care leaders in the future.

[17] Ibid, p.24.
[18] Ibid, p.24.

Table 2
Summary of Competencies and Skills Identified

Competency / Skill	Specific Skills
Communication skills	Public relations Ability to create shared values and vision Listening skills Verbal skills Policy development
Commitment to consumer	Identify, evaluate and implement strategies and processes Assess and improve the quality, safety, and value of health care Integrate needs of the individual with those of the community optimizing opportunities
Effective relationship building	Enhance the individual's ability to accomplish share leadership and foster teamwork and collaboration Build relationships, networks, and sustain alliances Develop cooperative relationships and effective information exchanges, stimulate social accountability and community stewardship build good board relationships Build good public relationships Able to influence people Build trust and credibility
Political awareness and sensitivity	
Systems thinking and systems-driven leadership	
Managing change and transition	Flexibility in managing change
Critical thinking skills	Problem-solving Research skills Analytical skills Conceptual thinking and flexibility Evidence-based decision making
Ability to manage culture	Creating and sustaining inclusive environments Creating engaging environments Anchoring changes in environment
Use of resources	Accountability
Self-management	Ability to balance home and work life Stress management

Source: Romilly, L. (2005). Development of a comprehensive situational analysis of human resources and skill needs of Canada's health executive/management sector. Prepared 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 and Skills Development Canada.

The required attributes that were also identified included:

- creativity;
- understanding of leadership models and styles, including own personal leadership style;
- emotional intelligence and ability to assess it;
- personal humility and professional will;
- ethical and values perspective; and,
- commitment to personal and institutional development.[19]

There are no studies or literature that document whether or not Canadian health care leaders/managers have these competencies and skills. Some of the reasons cited for the slow (if any at all) development of competencies include: the complexity of the health care leadership field resulting in challenges to achieving consensus on the necessary tasks and processes needed for successful outcomes; educational and experiential needs of health care leaders vary depending on the stage of development; and, the complexity of the health care system with complex adaptive systems that are not easily reduced to simple descriptions.

Formal training programs together with executive programs appear to be the primary vehicle for developing leaders in Canada.[20] There are no shortages of Canadian universities that offer MHAs, MBAs, and other formal degrees and executive programs. Some argue that the graduate education model is inappropriate for developing health care leaders and that what is required is a "practitioner-based learning model that focuses on developing emotional intelligence".[21] Mentoring has also been identified as a powerful tool to learn leadership skills. Recent studies report that corporations no longer defer to MBA programs to prepare future leaders. Rather, internal corporate development programs are utilized to train promising professionals. Recently, large health authorities have customized their own external and internal executive development programs. These same health authorities indicate though that graduate programs in health care management provide a "foundation for future leaders in health care".[22] This is mainly due to the little investment in executive development in hospitals and health organizations.

In the situational analysis, Romilly describes the different models proposed for developing health care leaders/managers but that none of these include any assessment of the different models'

[19] Ibid, p. 27.
[20] Ibid, p. 27.
[21] Ibid, p. 27.
[22] Ibid, p. 28.

effectiveness in producing leaders/managers. Romilly highlights that leadership development efforts are often seen as quick fixes and therefore fail. A number of factors impact the effectiveness of a leadership development program and include the reluctance of various interest groups to relinquish power thus making it difficult to lead; unclear delineation of areas of accountability; use of market principles that promote lack of trust; interference between performance and accountability; and a changing definition of performance measurements.[23]

Succession planning is part of the production component in the overall HHR Planning Framework. Succession planning practices can be either formal or informal. In a 2004 survey conducted for the American College of Health Executives and as reported in the situational analysis, 78% of the hospitals who responded admitted that succession planning was not routinely carried out. The most frequently cited reasons for not completing succession planning were that it was not a high priority, current CEO was new, and that there was not an internal candidate identified.[24] There are only a few instances of formal succession planning identified in Canadian health care organizations. These are reported in the situational analysis and are found in British Columbia (BC Ministry of Health Services), Newfoundland and Labrador (identified in a human resources study), and Quebec (Quebec commission on health and social services).

Stakeholders interviewed for the situational analysis report commented that there is a need to re-evaluate what is meant by succession planning given that the days of the 30 year employee are gone and that the younger generation of professionals has different career views as compared to the boomer generation. Senior level managers are also not mentoring younger and promising leaders although most of these managers will be retiring in the next 10 years. The CCHSE report to the Romanow Commission highlighted that with the elimination of many middle management levels and little time to mentor younger leaders, opportunities to develop succession planning has been reduced.[25]

There is a need to identify the right number of executives/managers needed in the health care system of the future and also, a common understanding of the minimum type of competencies and skills required. Questions are raised around the development of the current health care leaders/managers and whether or not there is any succession planning conducted to ensure the

[23] Ibid, p. 29.
[24] Ibid, p. 31.
[25] Ibid, p. 31.

continued production of these professionals. Very little has been written on these topics for health care leaders/managers but work for other health care occupations may assist in planning a research framework for a sector study of health care leaders/managers.

3.4 Management, Organization and Delivery of Health Services Across the Health Continuum and the Workplace Environment

Over the last number of years, the re-structuring and re-organization of the health care system across Canada has made managing and leading very challenging. A paper comparing US and Canadian hospitals as reported in the situational analysis concluded that there are fewer health administrative personnel in Canada due to the re-structuring activities of Canada's health care system. Results from the survey of 108 Canadian health care executives/managers' perceptions and experiences of the 1990s organizational and system-wide changes, point to the increase of work and responsibility for the Chief Executive Officer (CEO) given the flattening and reduction of senior management structures. This in turn leads to the increased work load and overtime that was cited earlier as part of the challenges in recruiting and retaining leaders/managers.

Similarly, in a study of the predictors of nurse managers' health, nurse managers were at risk for developing emotional exhaustion/burnout due to the re-structured health settings that resulted in lack of information, resources and support. Research conducted for the Quebec Commission concludes that the health care system has not recognized the strategic importance of its human resources and the need for a stimulating work environment to retain its best people. The Quebec Commission report goes on to claim that the turnover in Deputy Ministers of Health and other Ministry of Health positions (mainly, Assistant Deputy Ministers) has exacerbated the working climate for health care leaders/managers. Similar turnover in these positions have occurred in other provinces in the last several years.

What is not known is what the appropriate number of health care leaders/managers required to fulfill their functions and maintaining a healthy and balanced lifestyle. Romilly concludes in the situational analysis report that the human resource shortage issue across Canada has fostered consensus that a high quality work environment is at least as important as financial incentives to attracting and retaining motivated and productive health care workers.

4.0 Information and Data Gaps

The previous section provides a summary of some of the key human resource issues identified in the themes health human resource planning and forecasting, supply, production, and management, organization and delivery of health services across the health continuum and the workplace environment. Gaps in information and data are also discussed for the various themes and are summarized in this section of the report.

One of the main gaps identified throughout the situational analysis report is incomplete and inconsistent data. There is a lack of commitment to a common standard or common data gathering system. While there are efforts to address data issues in health human resource planning such as developing minimum data sets, national organizations like CIHI rely on the accuracy of input from the provinces and territories. Data may be available in some provinces, but whether or not it is comparable is questionable.

Most of the forecast models identified in the analysis do not include health leaders/managers. There is continuous debate as to the appropriateness of those models that are employed as some of these rely largely on counting the numbers of personnel relative to a given population and projecting forward to calculate future needs. Many argue that this forecasting does not provide realistic projections since it does not consider other variables that will have an impact. Thus, there is a need to broaden the focus and consider a number of variables in forecasting models.

Furthermore, there is uncertainty in terms of the number of health executives/managers currently employed in the sector. The 2001 census data uses the NOC to derive its statistics and reports the number of employees in each occupational group. Although health leaders and managers are included in five of the relevant managerial occupational categories as defined by NOC, other non-health care related professions are also included. Thus, final count of the number of employees is inaccurate for the health care leadership/management sector. At best, census data can provide an estimate of current supply provided that the assumptions made to reach this estimate is agreed to by the various parties.

One of the reasons for the lack of reliable data is the fact that this is not a regulated sector. Some of the studies cited in the previous section used data from a number of stakeholder organizations such as professional associations, educational institutions and employers. The collection and reporting of such data varies in content, format, data elements, definitions and time frames.

Furthermore, data collected by organizations typically conforms to that organization's mandate and interests. Primary and basic data (e.g., number of health care leaders/managers) will need to be collected to address some of the fundamental research questions raised in human resource planning.

The situational analysis report provides some information that exists on issues pertaining to the attractiveness of the sector. This qualitative information requires further confirmation and exploring since it is based on a small sample of health executives/managers consulted. Similarly, the analysis reveals preliminary observations of a number of competencies and skills required for a health leader/manager. This can be considered as a starting point and further confirmed in an attempt to achieve consensus on the competencies and skills needed. What is lacking though is information and data on the current competency and skill levels of health leaders/managers employed in the sector.

5.0 Conclusion

National health human resource initiatives recently completed or currently underway may assist conducting similar studies for health care leaders/managers. For example, methodologies employed in these studies can be modified and adopted for health care leaders/managers thus avoiding duplication of work. Other opportunities to raise the awareness of the critical human resource issues for health care leaders/managers and thus generate support and interest to act include:

- Capitalizing on funding earmarked for national coordination and planning;
- Including the impact of system design issues on recruitment and retention of health care leaders/managers in the linkage of health human resource planning to system design issues being considered by the advisory structure of the Conference of Deputy Ministers;
- Capitalizing on the fact that national health research organizations have identified health human resource planning as the number one research priority;
- Ensuring inclusion of health care leaders/managers in health human resource modeling and policy research; and,
- Capitalizing on the Pan Canadian Health Human Resources Strategy.

Table 3 summarizes the research questions outlined in the situational analysis and that can be used as a starting point for developing a research framework for a national human resource study of health care leaders/managers. These questions can be further classified as short- medium- and

long-term thus prioritizing the research activities and managing the magnitude of the work. Action oriented activities resulting in concrete deliverables should also be built into the research framework at each step to provide stakeholder groups with results they can use. For example, producing a report of best examples of successful succession planning will assist organizations currently facing this challenge and serve to further explore a critical human resource issue for health leaders/managers.

Table 3
Research Questions for Consideration

Theme area	Research Questions
Health human resource planning and forecasting	What model for forecasting and data collection will project future needs?
Supply of health care leaders/managers	• How many health care leaders/managers work in the health system in Canada? • How many health care leaders/managers will be needed in the future? • How many health care leaders/managers will be retiring in 5 years? 10 years? • Has re-structuring really changed the need for numbers of leaders/managers? • Is there a shortage of health care leaders/managers within organizations and/or in terms of the number of interested/qualified individuals available externally? • What are the common measurement tools to analyze workforce needs? • What could the health leadership and management sector do to attract health care leaders/managers?
Production of health care leaders/managers	• What are the trends in recruiting new health care leaders/managers? • What recruitment strategies work for the health leadership/management sector? • What retention strategies work for the health leadership/management sector? • What are the key competencies that health care leaders must have to do their jobs? • What are the key competencies (i.e., skills, knowledge, abilities, attitudes, and values) that health care leaders currently have to allow them to move through or across the health care system? Which degrees are desired and which have proven to provide the best background and are the most

	successful? • What leadership development is currently occurring in health authorities and organizations? • What has been the health care leadership/management sector's experience with succession planning? Is there a cohort of people who are exposed to different management/leadership levels and moving across operational functions and facilities? To what extent is mentoring and coaching used? To what extent is professional development used?
Management, organization and delivery of health services across the health continuum and the workplace environment	What types of organizational design of health organizations occur across the country and what impact do they have on numbers and types of leaders/managers?

Source: Romilly, L. (2005). Development of a comprehensive situational analysis of human resources and skill needs of Canada's health executive/management sector. Prepared 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 and Skills Development Canada.

There are a number of opportunities for the health care leadership/management sector to commence work studying its human resource issues in Canada. This discussion report and the situational analysis report completed in early 2005 identifies some of these issues and also proposes key questions to consider in further research work. The health care leadership/management sector can explore collaboration and grasp opportunities with federal and provincial/territorial governments given this stakeholder groups' recognition of the priority around health human resource planning. Synergies if not partnerships with health research organizations and other interested health stakeholder groups can also be forged given the current urgency in producing credible human resource data for health care. Awareness of the research challenges in particular the competing information gap, provides an opportunity for the sector to address these in developing the framework for a national human resource study. Lessons learned and results from other health human resource studies already completed can assist the sector avoid duplication and build a research framework to move forward with Pan-Canadian study. As concluded in the situational analysis report, a national sector study offers the health care leadership/management sector the opportunity to find some answers to the number of questions raised.

6.0 References

Building the Future: An Integrated Strategy for Nursing Human Resources in Canada (2005). *Research Synthesis Report,* May.

Canadian College of Health Service Executives in partnership with the Academy of Canadian Nurse Executives, Canadian Society of Physician Executives and Human Resources and Skills Development Canada (2005) *Summary Report National Stakeholders' Workshop: Human Resource Needs of Canada's Health Leadership and Management Sector*, March.

Curry, L. (2005) *Canadian Health Care Leadership and Management Sector Definition Study: Final Results of Decision Theoretic Modeling Exercise and Recommendations,* December.

National Occupational Classification. http://www23.hrdc-drhc.gc.ca/2001/e/generic/welcome.shtml.

Newland, J. (2005) *Leadership Task Force Report*. A joint project of: the Canadian College of Health Service Executives, Academy of Canadian Nurse Executives, Canadian Society of Physician Executives and Human Resources and Skills Development Canada, June.

Romilly, L., (2005) *Development of a Comprehensive Situational Analysis of Human Resources and Skill Needs of Canada's Health Executive/Management Sector*. Prepared for the Canadian College of Health Service Executives in partnership with the Academy of Canadian Nurse Executives, Canadian Society of Physician Executives and Human Resources and Skills Development Canada.

APPENDIX A

Roles Not Included in the Definition of a Health Care Leader/Manager

The following roles will not be included in the definition of a health care leader/manager for the purposes of a human resource study:

- provides direct care;
- provides services, resources, products, devices relied upon by those providing direct care (i.e., information technology, human resources, cleaning);
- works for companies providing health related services, products and devices at the interface with direct health care providers;
- works for companies providing health related services, products and devices at the interface with managers of direct health care providers;
- works for companies providing health related services, products and devices at the interface with senior leadership in health care institutions;
- works at senior management levels for companies providing health related services, products and devices;
- has any role in health product and supply organizations;
- conducts basic research in any aspect of science relevant to health;
- writes or presents critical appraisals of any aspect of science relevant to health;
- works for organizations that fund research on any aspect of science relevant to health;
- conducts research on any aspect of the health care system;
- writes or presents critical appraisals of any aspect of the health care system;
- works for organizations that fund research on any aspect of the health care system;
- works for any level of government with responsibility for any aspect of health care;
- are board or task force members for any agency or organization charged with studying or supporting any aspect of the health care system;
- are part of the ownership structure in a privately owned not-for-profit health care institution and,
- are part of the ownership structure in a privately owned for-profit health care institution or organization.

The definition of health care leaders/managers for the purposes of a human resource study will not include individuals who:

- possess an academic degree in health management (i.e., masters in health science administration (MHSA\;
- possess an academic degree in management (i.e., masters in business administration (MBA);
- are certified members of any health care profession providing publicly insured services (i.e., medicine, nursing);
- are certified health professionals directly providing health related services, products and devices (i.e., pharmacists);
- are certified members of any health care profession providing services not publicly insured (i.e., dentistry, physiotherapy, counseling); and,
- are certified managers in some other area (ie., Professional Engineers).

APPENDIX B

List of NOC Definitions Relevant to Health Care Leaders/Managers

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 to 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, and admissions director – health care, assistant director nursing services.

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

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.