

**The Changing Landscape of Healthcare Delivery in
Ontario and Implications for Health Human Resources:**
A Report on Research with Employers Conducted on Behalf of HOOPP

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HOOPP

Healthcare of Ontario
Pension Plan

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Introduction

The Gandalf Group is pleased to provide the Healthcare of Ontario Pension Plan (HOOPP) with this report on research conducted among healthcare employers in Ontario. The goals of the research project include understanding more about:

- the impact on health human resources brought about by the movement of services away from hospitals and to community settings
- and the relevance and importance of pensions to those responsible for human resources in community settings.

This project consisted of qualitative research conducted by means of in-depth one-on-one interviews, conducted by senior Gandalf Group personnel with healthcare employers working in different settings across Ontario. This report amalgamates our key findings across employers and analysis of differences among employers by type and setting.

The interview guide was designed to probe various issues around health human resources (HHR) challenges and pensions. This report identifies key findings with respect to:

- how new and expanding healthcare organizations in the community setting were faring with respect to HHR;
- how challenges faced by employers differ depending on setting, region and patient group;
- what challenges exist in relation to human resources (HR) in healthcare in the short- and long-term; and
- what proposed policies or solutions are being advanced to assist in meeting those challenges.

The focus of the research was with employers in the community setting – Family Health Teams (FHTs) and Community Health Centres (CHCs) as well as those working in community support and addictions and mental health services. We complemented our findings from these by conducting interviews with representatives of larger, more established healthcare employers: Community Care Access Centres (CCACs), hospitals, and Local Health Integration Networks (LHIN).

These interviews would allow us to compare our findings from interviews with those in smaller, albeit growing, areas of healthcare in the community setting by surveying counterparts who work in larger, more established and often acute care settings. By conducting research with



both those in the community setting and larger, more established organizations, we can learn what trends and concerns are unique to each and common to both.

Methodology & Interviewee Profiles

Between August 20 and October 7, 2009, senior Gandalf Group personnel conducted 46 interviews with managers, VPs, executive directors and others with responsibility for healthcare human resources at Ontario healthcare organizations.

The majority were conducted by phone and most lasted between 30 and 60 minutes in duration. Participants in Toronto were given the option of interviews in person or by phone, with half opting to complete them by phone and the rest in person (four were conducted in person in the GTA). The in-person interviews lasted on average one hour.

The Gandalf Group contacted managers and administrators at various organizations who would be responsible for HHR. With respect to CHCs or FHTs, invitations were sent to the executive director. For hospitals or CCACs it would be a VP or Manager to whom requests were addressed. A covering letter from HOOPP was sent to research participants, along with a letter from the Gandalf Group seeking participation in the research, outlining key themes and providing an assurance of confidentiality. The assurance of confidentiality is important to the quality of the interview results. For that reason, we do not reveal the responses of individual interviews. We provide aggregated responses, subdivided as appropriate into segments to provide more detailed insights and understanding of key sectors of the health care system.

Further to this, as with any such project, the list of potential interviewees must be large enough that the actual participants have confidentiality and cannot be derived from either the method of reporting or the nature of the interview list.

A focus on employers in community settings, with additional complementary interviews with employers in larger, more established organizations:

- 20 Family Health Teams
- 14 Community Health Centres
- 4 hospitals, 5 CCACs, LHINs, home care and community support providers, and community groups



Given the limited number of CHCs in the province, and the need to yield a significant number of interviews in each region, most CHCs in each region of the province were contacted. While most FHTs were contacted, many are not yet open or fully staffed and listings for some were difficult to obtain. Response rate to letters and emails sent inviting participation was about thirty-five per cent, meaning we talked with a significant percentage of the province's CHCs and FHTs. The interviews were relatively easy to schedule, in part because interviewees were interested in participating in research about community-based healthcare delivery and to support HOOPP's symposium, and also because many – especially HOOPP employers – have a positive view of or relationship with HOOPP.

Almost all interviews were held with organizations that directly employ healthcare professionals – three were held with association representatives who spoke on behalf of member facilities. The CHCs and FHTs we spoke to were located around the province. For the remainder of interviews – with hospitals, CCACs and LHINs, community support, addictions and mental health organizations – a sample of respondents were selected randomly from each region and contacted for interviews.

Interviewees included:

- 20 representatives of FHTs. Almost all were executive directors. Two offer HOOPP to their staff. These 20 FHTs were located around the province – the bulk in southern and southwest Ontario, some in the GTA and eastern Ontario and one in the Northwest of the province.
- 14 representatives of CHCs. Almost all were executive directors. Five of these CHCs offer HOOPP. Four were held with GTA CHCs, 8 with Southwest and Southern Ontario CHCs, and one with an Eastern Ontario CHC.
- 5 representatives of CCACs. These included Senior Directors and Managers responsible for HR. Interviews with these managers and directors focused on HR issues relating to the employees they hire directly. Most of these employees are HOOPP members. These CCACs contract out as well to employers who do not offer HOOPP. Locations included three in the GTA, and one in south west Ontario.
- 4 representatives of hospitals, including one Chief Human Resources Officer, two VPs responsible for HR and one director. Hospital locations included Toronto, Eastern Ontario and Southern Ontario and the Northwest.
- Of three remaining interviews: one was held with a LHIN, one with a service agency that provides home care and community care on contract and one with a representative of the mental health and addictions services sector.



Executive Summary

- With the creation in recent years of FHTs and the expansion of CHCs, the province of Ontario is moving integrated healthcare delivery into the community setting.
- One effect of this is that healthcare employers – regardless of type – are concerned about competition for healthcare professionals. Demand and competition for labour means employers are seeing “churn and turmoil” in the system. Even where vacancies are filled, turnover raises concern around continuity and quality of care.
- Managers are spending inordinate amounts of time on recruiting, retention and competition for personnel. Smaller healthcare delivery organizations in communities are not well equipped to respond to this pressure. They have limited resources for HR management. Most importantly, they are limited in terms of what they can offer in salary and benefits compared to what is offered by larger employers, notably hospitals.
- For community-based employers – notably CHCs and FHTs – the inability to offer competitive wages, benefits and pensions is the top human resources challenge. It reduces the pool of potential labour significantly and means these organizations are less able to recruit experienced professionals. To try to respond, these employers put a focus on offering the best work environment and work-life balance they can to existing and prospective employees.
- Over the long-term, these community organizations are concerned about the potential transfer of still more healthcare services to the community. Without a corresponding increase in resources and capacity, the ongoing transfer of responsibilities could significantly and negatively impact their capacity to deliver adequate services.
- Top of mind HR concerns of larger, more established healthcare employers – i.e. hospitals and CCACs – are managing and maintaining adequate staff levels within their budgets to meet more complex demands. While many have increased their personnel in recent years, hospitals and CCACs are confronting an aging population, and changes in the type of care and services they must carry out. As they work to manage staff levels to meet demand they must do so within strict budget constraints.
- Over the long run, they are concerned these pressures will be exacerbated by the effects of an aging workforce as a significant cohort of experienced senior personnel and managers – “baby boomers” – starts to retire.
- HOOPP is considered by employees as a valuable pension benefit for the income security it offers. It is valued by employers who can offer HOOPP and ensure they can attract and retain a pool of experienced personnel. For many healthcare providers in the community setting who do not offer HOOPP, and cannot offer salaries comparable to other healthcare providers in the system, the inability to offer HOOPP is a top of mind HHR concern.



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- The policy measures recommended by employers in the community that would be most important to their agenda include: standardization and portability of pensions and benefits; competitive wages or benefits for all employers and employees; the system be prepared to accept or absorb a shift in responsibility for healthcare delivery to community settings – it must build the human resource infrastructure to address those responsibilities.

Part Two – Health Human Resources Challenges in the Community Setting

The HR challenge that directors and managers of FHTs and CHCs are most worried about is the uneven playing field they face in terms of disparities in compensation and benefits between different healthcare employers.

Almost every representative of FHTs and CHCs we spoke with noted that one of their top three concerns when it comes to HR management is the salary disparity between what they pay and what hospitals or CCACs can pay. CHCs and FHTs report gaps in what they can pay nurses and nurse practitioners versus what some other employers can pay can be as much as \$15,000 to \$20,000 a year.

- Inability to offer competitive wages, benefits and pensions are top concerns. Reduces the pool of potential labour significantly.
- Less able to recruit experienced personnel.
- Focus on enhancing work environment and work-life balance.
- As organizations grow capacity to manage has been stretched.
- Over the long-term, community organizations most concerned about transfer of more services and implications for HR.

While CCACs and hospitals tend to offer better pay, benefits and pensions than CHCs and FHTs can offer, CHCs and FHTs in turn are thought to offer better compensation than community support agencies and mental health and addictions organizations. The gaps between what some healthcare organizations offer and some community and mental health organizations can offer are as great as 30% to 50%, according to our interviewees. Concerns that CHCs and FHTs face around attracting and retaining personnel as a consequence of wage and benefit disparities are exacerbated still further in other community settings. Community organizations feel they have become training centres, with resulting quality and continuity of care concerns that arise from turnover and professionals unfamiliar with the roster of cases.



As a consequence, many FHTs and CHCs are offering new hires with little professional experience the highest pay grade or level they can within the ranges set by the Ministry for salaries. This means they are maximizing budgets on salaries and leaving themselves with little room to manoeuvre within their budgets.

As with salaries, most representatives of CHCs and FHTs interviewed mentioned the competitive disparity they face when it comes to benefits and pensions. Many believe they cannot afford to offer good benefits packages (including HOOPP pension plan membership) under current funding allocations of 20% of salary. It would mean sacrificing other areas of benefits.

For community-based employers, the inability to offer competitive wages, benefits and pensions is the top human resources challenge. The inability to offer competitive compensation and benefits makes it difficult to hire experienced staff away from hospitals and settings that do. It reduces the pool of potential labour significantly and means these organizations are less able to recruit experienced professionals. FHTs and CHCs depend more on younger professionals than do hospitals. These community-based organizations have staffed up very quickly and often with younger doctors and professionals.

As many FHTs are new, their concerns to date have had more to do with recruitment and retention. Yet employers who have staffed up new centres and teams are still concerned that wage and benefits disparities will make it difficult to retain staff going forward. Some FHTs and CHCs are already seeing retention issues indicative of the underlying funding problems they face in comparison to hospitals. Some report that as employees or their families became impacted by the recession, with spouses laid off in other sectors, staff became more aware of the need for benefits and pensions. If other personal circumstances change, for example having a family, some staff express increased interest in benefits and pensions packages. Professionals that FHTs and CHCs have managed to recruit (many of whom have a preference to work in a community-based rather than acute-care setting) may yet be pressed to leave an FHT or CHC solely because of benefits, pensions or salary.

In terms of the plans that are on offer in the marketplace, FHTs and CHCs compare themselves to employers that offer HOOPP. It is the pension standard in healthcare in Ontario based on our interviews. Virtually none of the employers we spoke to were unaware of HOOPP. Many offer a group RSP but most of them are well aware it falls significantly short of HOOPP. Experienced employees put a premium on HOOPP because it's considered a good plan and they have an expectation that the plan can be transferred so as to maintain membership when moving from employer to employer. Those FHTs and CHCs that have arranged their finances in such a way as to offer HOOPP have had to cut benefits elsewhere and in turn carefully manage costs. However they have done so because they say it gives them a competitive advantage in attracting experienced professionals.



When it comes to addressing chronic vacancies for specific positions some community employers are looking to government programs to assist with the supply of professionals. One is the “Grow your own nurse practitioner” program which allows service providers to take advantage of Ministry funding to retain nurse practitioners after they have completed their studies generally in the communities where they live. Ruralty indices and ‘underserved’ designations maintained by the province allow those in certain regions to top up on salary with government assistance. Still others are looking to strategies to attract and retain International Medical Graduates.

But more FHTs and CHCs are taking their own actions to try to be competitive and compensate for what they cannot offer in salaries, pensions and benefits by putting a focus on other job attributes. These include measures geared to offering the best work environment possible and work-life balance to existing and prospective employees. For instance they can offer a four-day work week, or accommodate flexibility in scheduling to accommodate personal circumstances and preferences of professionals. This is over and above the fact that workload, stress and scheduling in community-setting (FHTs and CHCs specifically) are considered less arduous more or less across the board compared to the shift work in hospitals and the stress of acute-care settings.

A number of these new organizations are offering access to professional development and education programming as a recruitment and retention tool. For some FHTs this can include paid education days. Other FHTs allow professionals to participate in “learning collaboratives” – half-day sessions where practitioners come together to compare best practices relating to a topic or concern. Other employers will also offer wellness programs and generous vacation. FHTs and CHCs that are promoting the team or community approach are doing so in their HHR efforts as a means of distinguishing themselves. Promoting “Team” or “Community” models help to differentiate work experience from other settings. The model of care these new community-based organizations follow is attractive to some professionals. It means a different hierarchy and a different work environment, with the opportunities for all professionals and not just senior staff to contribute.

Ultimately, these attributes or offerings do not entirely overcome salary or benefits disparities. Even professionals who prefer the CHC or Team approach have told some managers and directors we spoke to that they have had to turn down offers or move back to acute care settings where the financial incentives are too great to turn down. Most executive directors in communities also know that many experienced personnel with hospital benefits are simply not interviewing for positions they are offering.

A consequence for FHTs and CHCs who offer flexible hours, the ability to transition between full- and part-time roles, access generous vacation or time off for professional development, is a more costly or burdensome onus on management vis à vis more complex scheduling. Having many part-time staff, as so many CHCs do, or staff who demand flexible hours in return for



lower pay means significant balancing acts for managers. FHT and CHC administrators have very small capacity to manage the range of administrative duties these growing organizations have been taking on.

While these various offerings - no shift work, a better work environment, flexibility of hours - allow FHTs and CHCs to be attractive to some professionals, their pool of potential experienced job applicants is clearly limited. Many therefore are looking to close the gap on pay or benefits and pensions, if not both, as well as ensuring transferability of pensions. Given the advantages they can offer professionals, some employers in the community setting say that they don't need to close the gap on salaries and pensions completely but that some effort to that end would be helpful - e.g. allocating not necessarily the same percentage as hospitals receive, or 25% of salary but at least 22% to 24% in lieu of the current 20% of salary.

A precarious HR situation with the potential to lead to systematic inequity in human resource allocation.

Doing so would at least create a standard across the system when it comes to salary and pensions: it would be understood that if the type of scheduling and number of hours worked changed from one setting to another that salary will vary; while the elimination of preventing portability of pensions would make for less of a stark choice when it comes to deciding on benefits.

Long-term Challenges for FHTs and CHCs in HHR

FHTs and CHCs differ from hospital managers we spoke with in that they are less focused on trends over the long-term and with discrete issues such as concern about an aging population in terms of its effect on healthcare delivery. FHTs are essentially completely new, and so we found they were seemingly less able than others to say where FHTs would be in 15 years with respect to HR challenges. Some we spoke with had been open for less than a year. As new organizations that have been in full expansion mode and hiring they are at very different trajectory points than hospitals.

Over the long-term, these community organizations are most concerned with the potential transfer of still more healthcare services to the community (e.g. responsibility for treating more chronic diseases).

Their concern is whether they will have adequate resources or whether they will continue to be asked to take more on without commensurate resources.

To date, community-based healthcare providers have been called upon to manage responses to specific chronic diseases such as diabetes through provincially mandated strategies. This



has meant recruiting personnel to manage programs that target at-risk communities and those suffering from diabetes. What is clear is that this shift means increased responsibilities for community-based non-acute facilities. An important question throughout this research was how those on the front lines can manage and build up the new health human resources infrastructure required to enable this change – now and in the future as services continue to be transferred. CHCs are aware that they are expected to take on more of these services now and in the future.

CHCs in particular believe their workers are being asked – and will continue to be asked – to do more with less as they work with LHINs to transfer programs from hospitals. They along with FHTs believe that if care is being shifted to the community, the province has to recognize that they need to build the infrastructure – including human resources infrastructure – with increased if not commensurate salaries or pensions/benefits. Without a corresponding increase in resources, the ongoing transfer of responsibilities could significantly impact their capacity to deliver adequate services.

Many CHCs are already facing pressure in that they have opened satellite offices with additional government funding but are still functioning with much of the same sized management structure, despite the increased workload. As CHCs have grown, leadership skills training for more complex and larger staff levels must keep up. CHC and FHT executive directors are struggling to manage organizations with minimal overhead and support. They have minimal capacity to manage human resources for instance – it is just one responsibility among many, along with financing, contracts, real estate and administration. One CHC director cited a Hay Research report that suggested management at such facilities were experiencing under funding of 25% relative to need in management-related costs and responsibilities.

This will become more of a concern as more services are moved into the community and as existing directors and managers retire. Senior managers we spoke with from larger facilities (e.g. CCACs) likewise questioned whether there is adequate training to prepare existing staff to manage more responsibility and to exercise leadership – both in their organizations and at others in the healthcare system.

Regional Concerns for FHTs and CHCs

The human resources challenges we have discussed thus far facing community-based employers affect providers of care in communities across the province. However, regional differences are an additional or exacerbating concern when it comes to recruitment.

Many communities in the province consider themselves “under serviced” – so designated for their shortage of specialized or regulated health professionals. These communities are not simply in remote regions however; they include communities in south-western Ontario, Windsor-Essex and the Niagara region.



In the North of the province ramifications of job vacancies pose additional challenges for the system and patients: e.g. if treatment or service is suspended because of a vacancy in a certain position (be it a doctor or dietician) it can mean either costly travel or the need to seek flexibility in allowing one health care professional to substitute for another: e.g. a nurse practitioner in lieu of a doctor or dietitian.

Equally interesting in the redesign of healthcare towards the community is attracting doctors to salary-based positions in the community – this appears to be a problem for CHCs in smaller communities in particular. CHCs in these communities were encountering the greatest difficulty recruiting salaried physicians, based on their responses.

Employers in large urban centres have access to a larger pool of professionals and those at universities and educational training centres. This is a recruitment advantage. It doesn't however prevent turnover or retention issues or mean they can attract experienced personnel. In Toronto it means many of the professionals employers hire are placement students, in comparison to CHCs elsewhere – their location close to teaching hospitals and universities means they have a ready supply.

Part Three – HHR Challenges at Hospitals and CCACs

In contrast to what we heard from managers and directors in community settings, administrators with hospitals and CCACs were less concerned about the compensation and benefits they can offer professionals. They do not cite any disparity they face with other employers when it comes to wages, benefits and pensions. They are aware that HOOPP is a valuable offering to personnel. However their recruitment realities differ from those of community-based settings and as such the value of their benefits and compensation is not understood the way it might be in community settings. Some hospital and CCAC administrators told us they recruit or hire internally, or do the bulk of hiring from similar healthcare organizations that offer similar pensions and salary ranges. And unlike FHTs, they have not been recruiting for new organizations so recruitment has not been a focus as it has been for FHTs and some CHC directors.

Hospitals and CCACs we spoke to have mostly been increasing staff levels in recent years. That having been said, the top of mind HR concern of these administrators is less about recruiting personnel and more about managing staff levels within their budgets to meet more complex demands.

Hospitals in particular are concerned increasingly about managing their budgets. Those budgets mean restraints on the staff levels they can maintain. It may mean cuts for some. But in the near to medium term it means considering whether the complement of staff they can maintain within their budgets can manage growing demand for health care particularly in surge or crisis modes such as a flu season or an H1N1 pandemic scenario. This type of insight stands in contrast with



the perspectives of FHTs and some CHCs who are in full expansion mode. Hospitals may have been increasing staff last year but are well past the trajectory point of “staffing up.” They are less likely to be considering growth or opening a new satellite and more likely to be considering what they can accomplish within their limited budgets.

These concerns are compounded by the increase in demand for services that these hospital administrators and CCAC management are witnessing. They are already seeing complications stemming from the aging population’s demand for health care. These looming issues (such as demand from aging patients, who require complex care) were much more pronounced in discussion with these employers compared to interviews held with FHTs and CHCs.

Challenges at Hospitals, CCACs

- Larger, more established employers – hospitals and CCACs – are most concerned with having adequate staff levels within their budgets to meet more complex demands.
- Recognize that wages, benefits and pensions are a competitive advantage.
- Facing the realities of more complex HR management and on a larger scale.
- Responding to competition for labour by enhancing work experience, environment.

CCACs are perhaps on the front lines of the demographic challenge more than any other organization type we interviewed – e.g. more complex cases dealt with in patients’ homes. This is a result of the planned or deliberate transfer of certain services out of hospital settings. So while CCACs have increased staff in recent years they still believe it has not been enough to keep up with the number of cases and certainly the types of cases. A home visit that might have taken two hours now takes four, was one CCAC representative’s example. They can clearly see what the aging population will bring– a trend that will play itself out over the next two decades.

Even though employers or managers at CCACs may be in a position to pay better wages and pensions than FHTs and CHCs, even these employers report turnover and movement around the system of many personnel. Oftentimes these personnel are leaving for another CCAC or service provider who can offer a different work environment or set of responsibilities. CCACs have been expanding and as such are competing with each other for staff and personnel. If salary and pensions are not what differentiates them or makes them attractive it could be the work environment, the management style, granting the ability to work from home and thereby cutting down on commute times. These are just some examples. These are elements of the work place that drive competition for professionals as much as salary and pensions for those employers who offer competitive wages and benefits. CCACs are looking at flexible hours and working from home as ways of improving work experience, responding to burn out and staying competitive with what others are offering.



Arguably – and a few interviewees raised this – the patchwork not simply of salary and pensions standards but also different employers in the Ontario system, each with different management approaches, exacerbates the competition for personnel. In this respect, HHR in Ontario stands in contrast to the school system in the province or the healthcare system in provinces where the health authority may be the employer across a range of facilities for instance.

CCACs face additional human resources challenges stemming from the merger of CCACs that occurred province-wide earlier in the decade. Professionals and HR managers have had to assume more leadership for more workers and case loads in larger organizations. This means managers have had to consider whether their senior staff has the capacity to lead teams and manage caseloads across much larger organizations with more employees than was the case prior to CCAC amalgamation. A concern therefore is how managers can develop “leadership” skills and capacity for more complex management. Some directors we spoke of at larger facilities question whether there is adequate training to prepare existing staff to manage more responsibility, change and leadership, especially if caseloads continue to grow. “Leadership” will be an issue with retirement of older workers in the baby boom, which will prove to be an issue for all facilities.

Long-term HHR Concerns for Hospitals and CCACs

One of the most pronounced long-term concerns of CCACs and hospitals we spoke with is the retirement of an aging workforce.

An interesting challenge for large employers is that while they know many workers will be retiring they don’t know precisely when staff will be retiring. Planning for this in the short run is very difficult. They don’t know if baby boomers may retire suddenly or en masse. Economic circumstances of the last year for instance are reflective of things that can change career plans. This is a problem within a problem when it comes to the aging workforce – i.e. managers know a looming shortage is coming, they just don’t know when. To that end, actuarial advice that could provide administrators insight on likely retirement rates could help employers with large-scale HR planning.

FHTs and CHCs were less likely to raise these concerns. They have a different focus to community care than CCACs and community support organizations, who manage somewhat different types of patients and caseloads. FHTs are in essence completely new, so the consequences or concept of losing a cohort of personnel with long experience in their organizations must seem beyond the horizon at this point. The idea of a mass retirement would seem remote after having only just staffed up. They are essentially operating on shorter timelines. As FHTs and CHCs pay less than at hospital it is likely that on average their professionals are somewhat younger.



Part Four - The Role of HOOPP

HOOPP is valued by employees for the income security it offers and by employers in that it can help them attract and retain a pool of experienced personnel. Virtually all administrators knew of HOOPP and hold it in high regard as a pension plan with very good performance.

In interviews with 46 healthcare employers, the majority of respondents told us that HOOPP provides employers a net benefit when it comes to recruitment and retention and that the majority of members value the plan highly.

Among community groups, CHCs and FHTs (the majority of whom do not offer HOOPP) the competitive advantage HOOPP provides is especially apparent.

When we asked community groups, CHCs and FHTs to name the top three human resources concerns they face, the majority raised inadequate funding for benefits and pensions – it was the top concern along with inadequate budget allowances for salaries. Almost all who do not offer a pension plan wanted HOOPP as a benefit they could offer to assist them in attracting experienced employees.

Out of 35 interviews with representatives of community groups, CHCs and FHTs, 32 respondents agreed that being able to offer HOOPP would be beneficial in meeting their recruitment and retention challenges. Examples and comments are excerpted below.

While some CHCs and most FHTs are new, and their experience with retention issues is minimal, some have already seen professionals leave because HOOPP was offered elsewhere.

Of the 28 remaining representatives of community groups, CHCs and FHTs we spoke with, eight could cite specific instances where professionals had left them or turned down job offers they had made solely because of the lack of a HOOPP pension. Almost all of these facilities offer a group RSP.

All 7 CHCs and FHTs we spoke with that offer HOOPP were able to cite instances where having the plan allowed them to recruit people they otherwise couldn't have. They said the quality or quantity of job applicants was enhanced by virtue of their being able to offer HOOPP.

CCAC and Hospital administrators were somewhat less likely to place an emphasis on the role HOOPP plays in recruitment. They were not as likely as community-based employers to tell us unprompted that HOOPP makes a difference in recruitment and retention. However, one Toronto hospital administrator we spoke to was clear about the value it provides his organization, calling it a “‘Cadillac’ pension plan,” saying “we use it aggressively in our recruiting.” Some of the similar comments we heard from employers in community settings are as follows:



HOOPP Employer CHC - "We knew we had to offer something..." HOOPP is "enticing." "Pensions are more a concern than ever. Having HOOPP made us stand out..."

HOOPP Employer CHC - "We recruited 2 nurses who wanted to come for some time and didn't join until we finally got HOOPP."

HOOPP Employer CHC - "HOOPP helps attract more senior qualified people....It allows me to fill positions I would otherwise not be able to fill." Not having HOOPP "would require more flexibility on job descriptions, hours etc."

HOOPP Employer FHT - "Three people joined us only when we confirmed we had HOOPP.. Another person came because they didn't have HOOPP in their current job."

Non HOOPP Employer CHC - "Hospital staff cannot take a reduction or lose HOOPP...3 nurse practitioners in last 2-3 years turned down job offers because HOOPP was not offered.... 70% of our staff want HOOPP."

Non HOOPP Employer CHC - Pensions are a "huge concern." "When our staff starts to have families they leave for a pension elsewhere...People leave because of salary and pensions....If pensions were offered in the community there would be more movement from hospitals to the community."

Non HOOPP Employer CHC - "Pensions would improve the pool available....Dissatisfied hospital workers say salary and benefits are reasons they don't leave to join us...the pensions piece would get staff out of hospital."

Non HOOPP Employer CHC - "Number one recruiting issue is not having HOOPP."

Non HOOPP Employer FHT - With HOOPP "we'd get older more experienced professionals...We lost a social worker to a hospital because we did not have HOOPP."

Community-based managers and directors do allow that not all personnel may value HOOPP as highly as others. Younger professionals or those whose spouses have benefits and pensions may be less likely to see the attractiveness of benefits. This is coupled with the fact that employees with lesser salaries (and these are arguably more numerous in the FHTs and CHCs than in hospitals or CCACs) may not want to lose "cash in lieu" or see salary diverted to a pension plan. This is generally not a reason why CHCs and FHTs have not taken on HOOPP – affordability remains the key barrier. Based on how they are funded most believe it's out of reach. But if they could afford it many would want to understand options for flexibility in terms of allowing employees to opt out.



The sense from most community healthcare providers we spoke with was that while they and their employees mostly want HOOPP they see no way they can afford it. Further to that, some of these FHTs and CHCs believe they have no voice in the system and that the salary and benefits guidelines they work within reflect that. Within the system of healthcare providers, community based employers tend to feel voiceless in comparison to other employers and healthcare organizations. As smaller and newer entities, many have not been part of the same tradition of advocacy as other organizations in the healthcare system, such as the OHA or OMA.

Conclusions

This round of research confirmed some general themes that we have drawn from quantitative surveys with Ontarians on behalf of HOOPP in November 2008 and March 2009. Specifically, it confirms a sense that pensions are very much top of mind for workers as well as employers. They also appear to be an integral part of ensuring quality personnel are providing health care.

These hypotheses and concerns are echoed by the findings from our interviews with employers. The issue of pensions for healthcare professional and the top HHR concerns of employers are closely related. When we ask about top HHR challenges, pensions come to the fore, unprompted, with many community-based interviewees. Pensions – and HOOPP pensions in particular – are important to prospective hires at healthcare facilities and important to managers responsible for ensuring the right personnel are in place providing quality care. And to be sure, most professionals according to the employers we spoke to would prefer a HOOPP plan over a group RSP, even though most in the community that we spoke to offer the latter.

- There are at least two different HR infrastructures.
- Without standard compensation, benefits and staffing up may be manageable but systematic problems may emerge due to differing, available labour pools.
- Employers –especially in the community with poorer wages, benefits, pensions – will spend inordinate time managing HR due to retention issues and part-time work force.

As we examined progress in HHR changes in community organizations and elsewhere, we see that the province and employers have made significant progress in reorganizing healthcare delivered in the province. New FHTs and CHCs have brought together new teams of professionals and a new approach to primary and interdisciplinary care in many communities.

However, there are at least two different HR infrastructures – one found in the community setting and one which exists in larger, institutional settings. Without standard compensation and benefits, staffing up may be manageable for those in the community but systematic problems may emerge due to differing, available labour pools. Employers – especially in the community



with lower wages, benefits, and pensions – will spend an inordinate amount of time managing HR due to retention issues and part-time work forces. The allocation of HR will be inequitable with younger, less experienced and part-time employees in the community. As more services are transferred to the community, these pressures could be compounded.

- Employers are looking for more standardized HR policies across the system so allocation of resources matches allocation of responsibility for service delivery.
- The challenge is to build a human resources infrastructure that is sensible across settings so SETTING is the primary motivator for employment, not wages, benefits.

While most FHTs and CHCs expressed concern around both salaries, and benefits and pensions, some believe that being able to offer HOOPP would be more a likely, logical and appropriate response than closing the gap on salary. Some told us that while salary gap is significant, if they had to close one gap it would be on pensions: i.e. that some workers are willing to take the hit on salary but not on pensions or that salary disparities are offset by hours worked and scheduling.

The policy measures recommended by these employers that would be most important to their agenda include:

1. Standardization and portability of pension/benefits allow healthcare workers to move around and allows different settings to be able to hire the best and the brightest and most experienced that fit with their setting
2. Competitive wages or benefits for all employers and employees – FHTs and CHCs do have the advantage of no shift work and perhaps better and more flexible work environments but are significantly disadvantaged by not being able to offer comparable benefits and pension. Currently they receive an allocation equivalent to 20% of salary and they are looking for at least 22% if not 24% or 25%.
3. In the long-term the additional concerns is that the Ministry or LHINs cannot simply shift responsibility to community settings – they must build the human resource infrastructure to address those responsibilities. This reinforces the importance of points 1 and 2.

Many employers are looking for more standardized HR policies across the system. This could help facilitate a more effective transition of resources to the community level. It would help stabilize a situation where currently employers are all working to compete for labour and instead allow different parts of the system to work together in an integrated fashion. Fundamentally, the challenge or goal in employers' eyes is to build a health human resources infrastructure that is sensible across settings so that the setting is the primary motivator for employment, not wages, benefits and pensions.

