

Newfoundland and Labrador
Health Human Resource Indicator Report 1999 to 2003
Executive Summary



**GOVERNMENT OF
NEWFOUNDLAND AND LABRADOR**
Department of Health and Community Services

The Health Human Resource Indicator Report 1999 to 2003 is comprised of the following separate documents to facilitate ease of distribution, verification, and update:

Executive Summary

Introduction

Part 1 – Who’s Who

Part 2 – Full-Time Equivalents

Part 3 – Overtime, Callback, and Relief

Part 4 – Workforce Wellness

Part 5 – Workforce Movement

Part 6 – Retirement Estimates

Part 7 – Definitions

This document is:

Executive Summary

This document provides an executive summary of all parts of the Human Resource Indicator Report 1999 to 2003 which collectively form the analysis of trends and key indicators for the Newfoundland and Labrador health boards’ workforce. For the purposes of dissemination, the Executive Summary and Introduction will be attached when one or more of the parts of the report are distributed.

Health Human Resource Indicator Report 1999 to 2003 Executive Summary

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The Health and Community Services Human Resource Planning Unit represents a partnership agreement between the Government of Newfoundland and Labrador Department of Health and Community Services, and the Newfoundland and Labrador Health Boards Association. Please direct inquiries related to this report to the Newfoundland and Labrador Health Boards Association.

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—Introduction—

This document represents the third iteration for the collection, analysis and reporting of health board human resource data. It has evolved from a few indicators for a selected number of occupational groups to a wide range of statistics for the entire health board workforce.

The initial report, Health and Community Services Baseline Human Resources Indicator Report (June 2000) provided an analysis of about 60 pieces of data on 12 occupational groups in 1999 collected from each health board. Achieving consistent and reliable results proved to be a challenge. The second report, Health Human Resources Indicator Report 2000/2001 (October 2002) collected data at a much lower level of detail, for more occupational groups, using data from health boards' information systems to obtain fiscal year 2000/01 data. This report, Health Human Resource Indicator Report 1999 to 2003 collected earned hours and other data for all occupations in the system, for two fiscal years 2001/02 and 2002/03 and presented an analysis of trends for all years where possible.

Due to the increase in the scope and nature of the data, this report differs from the previous two in several ways. First, naming and grouping of occupations into meaningful categories was required. As such, the following nomenclature was developed:

Primary Occupations

Primary occupations provide direct patient care, diagnostic services, or manage the health system (including clinical and non-clinical managers). They also meet one or more of the following conditions: there exists a regulatory body and/or professional association, and/or their post-secondary educational background is generally in excess of a single year (i.e. technologist vs. technician). Examples include registered nurses, psychologists, medical laboratory technologists, and speech language pathologists.

Ancillary Occupations - Clinical

These are individuals that do not fit the **Primary Occupations** category but may provide direct patient care or diagnostic services, and generally work under the direction of primary occupations. Examples include medical laboratory technicians, personal care attendants, and recreation therapy workers.

Ancillary Occupations – System

These are individuals that support the health and community services system. They do not fit the **Primary Occupations** or **Ancillary Occupations – Clinical** categories. Examples include laundry, dietary, housekeeping, and information systems staff.

Secondly, for ease of update and dissemination, the report was divided into parts according to topic. Data was compiled based on the 14 health boards that existed at the time the data was collected. It is possible to recompile the data by the four regional integrated health authorities as required. Finally, it was impossible to include all supporting detailed data in appendices due to the volume. Specific detail and/or custom summaries are available upon request.

—Who's Who—

The health and community services system in Newfoundland and Labrador (NL) was comprised of approximately 17,814 individuals, in addition to 913 physicians, as of March 31, 2003. Sixty-one per cent of the system was comprised of primary occupational groups. Excluding physicians and students, health boards employed approximately 82 per cent of the primary occupation groups referenced in this report, with the remaining 18 per cent employed by private and other public organizations. Within the health boards, almost 50 per cent of the workforce, excluding physicians and students, was concentrated in two health boards.

The average age of health board workforces was 42.7 years of age. Three health boards had workforces with an average age almost two years older than the average age for the entire health and community services system.

Seventy-six per cent of the health board workforce was permanently employed. Three health boards classified over 80 per cent of their employees as permanent, although there is inconsistency in naming conventions and caution should be used in interpreting this statistic.

—Full-Time Equivalents—

A full-time equivalent (FTE) is defined as the total number of earned hours divided by the normal earned hours. The total number of FTEs in the health boards' workforce, excluding physicians and students, in fiscal year 2002/03 was 15,051. Fourteen occupational groups, numbering 125 FTEs or higher, made up more than 90 per cent of all the earned hours. Three functional centers collectively accounted for more than 25 per cent of all FTEs: Long Term Care Nursing/Resident Unit (14.3 per cent), Housekeeping (6.5 per cent), and Patient/Resident Food Services (5.8 per cent).

The percentage of earned hours coded as regular was highly variable. This depended strongly on the attributes of the health board workforce and patterns of leave. Illness, injury, and other leave (such as vacation, compassionate, jury duty, etc.) accounted for 3086 FTEs (20.5 per cent of all FTEs) while relief, overtime and callback combined accounted for 1761 FTEs (11.7 per cent of all FTEs).

Worked to earned ratios indicated the percentage of time employees were carrying out the assigned duties of a functional center. For the entire workforce in fiscal year 2002/03, excluding physicians and students, the ratio was 79.5 per cent (i.e. per cent of time at "work"). For the "average" full-time employee (52 weeks), this breaks down into about 35.3 weeks of regular time, 5.0 weeks of relief, 1.0 week of overtime and/or callback, 4.0 weeks of injury and/or illness leave, and 6.7 weeks of other leave such as vacation, compassionate, jury duty, union, statutory holiday, education, and other miscellaneous paid leave. There was much variation at the health board and occupation level, with some ratios falling below 70 per cent. This equated to five weeks of leave per FTE more than the provincial average.

—Overtime, Callback and Relief—

Overtime, callback and relief as coded by health boards accounted for a total of 1761 FTEs or 11.7 per cent of all earned hours. Of this total, relief accounted for 1460 FTEs or 9.7 per cent of all earned hours, and overtime and callback combined accounted for 301 FTEs or 2.0 per cent of all earned hours (1.7 per cent as overtime and 0.3 per cent as callback).

At the provincial level, overtime in quantity was dominated by registered nurses and licensed practical nurses however, when expressed as a per cent of all earned hours, several small specialized groups tended to dominate, including radiation therapists, medical physicists, cardio-pulmonary technologists, paramedics, and biomedical engineering staff. Callback was most prevalent in quantity and rate by medical radiation technologists, and combined laboratory x-ray technologists and technicians, all diagnostic areas. Facilities staff also utilized callback as a mechanism to maintain 24/7 services. Specific health boards relied heavily on overtime and callback, primarily for registered nurses.

Total FTEs of benefit leave in the system equaled 3087 FTEs while total relief as coded by health boards equaled 1460 FTEs. This equated to approximately half of all benefit hours having a corresponding relief hour, however relief as coded by health boards likely understates the actual incidence of relief, due to coding practices related to overtime, callback, and float staff.

Health boards with significant long-term care services had the highest per cent of FTEs of relief hours, probably due to the relatively stable staffing requirements. Similarly, occupational groups working eight-hour, weekday shifts generally utilized low relief, overtime, and callback. Other services where personnel are required for services 24 hours a day tended to have higher relief, overtime, and callback rates.

—Workforce Wellness—

A complete analysis of workforce wellness would include health and safety initiatives, and physical and emotional health of an organization. This report was limited to workforce wellness as characterized by injury leave, sick leave, and grievance rates. Injury and sick leave combined accounted for 1151 FTEs or 7.7 per cent of all earned hours.

Injury leave was prominent for several occupational groups. In the primary occupations category, licensed practical nurses and registered nurses had the highest percentage of their total earned hours in injury leave in 2002/03. Personal care attendants, paramedics, and housekeeping and dietary staff had the highest percentage of their total earned hours in injury leave in the ancillary occupations categories. Three health boards averaged more than three per cent of their total earned hours in injury leave in 2001/02 and 2002/03. In total, the average health board employee lost 40.2 hours or five days (at 7.5 hours per day) in 2001/02 and 33.7 hours or four days (at 7.5 hours per day) in 2002/03 to injury leave.

Sick leave represented 5.6 per cent of total earned hours for all occupations in 2002/03. In the primary occupations category, licensed practical nurses and registered nurses had the highest percentage of their total earned hours in sick leave. Paramedics, personal care attendants, and housekeeping and dietary staff had the highest percentage of total earned hours in sick leave in the ancillary occupations categories. Paramedics also had the highest percentage of total earned hours in sick leave for all occupational groups including the primary occupation category. Six health boards averaged over six per cent of total earned hours in sick leave. In total, the average health board employee lost 90.9 hours and 91.9 hours in 2001/02 and 2002/03 to sick leave respectively, or approximately 12 days (at 7.5 hours per day) annually.

The number of grievances generated by employees could be considered as a proxy measure of employee satisfaction. In 2001/02 and 2002/03, grievances were filed at a rate of 6.0 to 6.6 grievances per 100 employees respectively, and resolved or dropped at a rate of 2.5 to 3.1 grievances per 100 employees respectively, although this figure is understated due to data quality issues. Of ten health boards able to provide complete information, eight reported that grievances were being generated faster than they were being resolved or dropped. The three largest health boards were not able to provide complete information in this regard and figures should be interpreted with caution.

—Workforce Movement—

Workforce movement is difficult to understand and quantify. By examining various statistics such as the number of vacancies, hires, separations, and resulting turnover, some measures of workforce movement can be made. The underlying caution is the noticeable variation in statistics. Some of this variation was due to data collection and quality issues, but much was because of normal fluctuation. Many groups are small in size and caution is noted in interpreting workforce movement trends.

The vacancy rate is the average number of vacancies per quarter as a percentage of the total workforce; the average vacancy rate for primary occupations in the health and community services system was 1.6 per cent. A notable group was pharmacists who consistently had between two and seven vacancies out of a workforce of 82. Audiologists and pharmacists also had the longest average vacancy periods and most positions were deemed by health boards to be “difficult to fill”. Data collected over four years showed much variability in the number of internal and external hires by occupation.

Turnover is defined as the number of separations expressed as a percentage of the workforce. Over the four-year period of 1999 to 2003, primary occupations reported a range of four per cent to 33 per cent annual turnover. The lowest turnover was for medical laboratory technologists and medical radiation technologists, both under 4.5 per cent while the highest was for audiologists and radiation therapists, at more than 25 per cent (these latter two groups number under 20 employees provincially). Registered nurses and licensed practical nurses had average annual turnover rates of 6.4 and 4.8 per cent respectively. Generally, occupational groups with rates of turnover of approximately 10 per cent or higher tend to be small in number, and are comprised of young, mobile, health professionals. Most of these occupational groups are trained out of the province. Overall, for occupational groups exceeding 250 in number provincially, turnover rates seem reasonable, although national benchmarks and comparators on this topic are difficult to locate. Note that provincial numbers mask local variations reported for some rural areas or sub-specialties. A separate study of turnover in two health boards, and the use of an alternative method for calculating turnover, both showed general agreement with the above results.

—Retirement Estimates—

Age-based retirement projections were constructed for a ten-year period. Estimates were based on the demographics of the workforce as of March 31, 2003. A grouping methodology to classify retirement estimates into low, moderate, and high categories was used, based on the projected percentage of the workforce expected to retire over the ten-year time frame. At the provincial level, occupational groups in the “high” category, or more than 40 per cent projected to retire in the next ten years, included cardio-pulmonary technologists, cardiology technologists, prosthetist-orthotists, managers, orthopedic technologists, audiology technicians, prosthetist-orthotist technicians, medical radiation technicians, combined laboratory and x-ray technicians, physiotherapy assistants, and psychology assistants. Many of these occupational groups are highly specialized and relatively small in number.

Primary occupations in the moderate category (between 15 and 40 per cent projected to retire) included orthopedic technologists, medical laboratory technologists, medical radiation technologists, electroneurophysiology technologists, licensed practical nurses, registered nurses, radiation therapists, clinical psychologists, pharmacists, social workers, and nuclear medicine technologists. Although these groups fell into the moderate category, their numbers were quite large and the impact of retirements could be severe. Several ancillary groups also fell into the moderate category. Careful planning is required to avoid potential gaps in service, especially for specialized group that are small in number and in some locations therefore supporting the need for regional planning and monitoring.