

**Recruitment and Retention in the Health System
A Discussion Paper**

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Prepared by:

**Leslie Harnett Human Resource Consultant
Regina Coady Project Manager
Health and Community Services Human Resource Sector Study**

Note:

This discussion paper does not necessarily represent the position of the Newfoundland and Labrador Provincial Human Resource Planning Steering Committee or its' stakeholders. The function of the paper is to summarize the literature and research on available on recruitment and retention in the health system and propose possible solution strategies to address these issues. It is meant for discussion purposes and to generate responses and feedback from stakeholders. Based on this feedback, the Human Resource Planning Steering Committee will develop final recommendations.

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1 Introduction

As the national and international competition for health human resources escalates, the development of recruitment and retention strategies becomes increasingly important in maintaining health services in any region. Strategies that take into account quality of worklife, workload/skill mix, professional development and financial incentives have been shown in the literature to affect an organizations ability to recruit and retain motivated professionals.

Both the RN/LPN and Allied Health Subcommittees identified quality of worklife and recruitment and retention as priorities for developing a comprehensive human resource plan. The committees combined their resources and developed a paper that would discuss the recruitment and retention of the respective groups. Sections on Physicians and Managers in the provincial health system were later added by drawing on provincial research that had already been completed, examining job satisfaction of the respective groups, amongst other things. It should be noted that, although this discussion paper is restricted to the abovementioned groups, the literature review is relevant for any health professional group. The recommendations presented are applicable to all of those employed in the provincial health system, and not only those groups identified and discussed in the paper.

This discussion paper is intended to examine the recruitment and retention of health professionals in Newfoundland and Labrador. It does so through a review of the literature around four major themes: quality of worklife, workload/skill mix, professional development and financial incentives, all issues which are essential to a successful recruitment and retention plan. Each of these issues are then discussed in relation to allied health professionals, registered nurses (RN) and licensed practical nurses (LPN), physicians, and management in the provincial health system, drawing on relevant research and information from provincial stakeholders. Tools of effective recruitment and retention are presented and discussed, followed by a summarized list of potential recommendations that will assist in making Newfoundland and Labrador a province which is able to attract and retain qualified, motivated health professionals.

This discussion paper is limited in that it does not discuss all professional groups employed in the provincial health system, and it is therefore not all encompassing. Due to the time frame of the Provincial Health & Community Services Human Resource Sector Study, all groups employed in the system could not be included in all components of the research. The amount of provincial research available on each of respective professional groups was also limited. Much of what is heard in the provincial health system on recruitment and retention is anecdotal, so it was necessary to draw of national and international research available on factors effecting recruitment and retention.

2 Quality of Worklife

In order for an organization to be successful in recruiting and retaining motivated professionals, a culture in which the quality of worklife of its employees is identified as a strategic priority is crucial. O'Brien-Pallas and Baumann (1992), through a review of the literature, identified two broad categories of factors that influence nurses' quality of worklife: internal and external dimensions. It is the interaction of these internal and external dimensions that influence the health professionals' quality of worklife and outcomes of care. While the model is discussed using the nursing profession, it can be applied to all health professional groups.

Internal dimensions include those factors central to the professional and the environment in which he/she works (O'Brien-Pallas & Baumann, 1992). The internal dimension includes four major factors:

- Individual,
- Social/environmental/contextual,
- Operational, and
- Administration.

Individual factors include the home-work interplay and individual needs.

Social/environmental/contextual factors include climate, decision making/management style, career laddering, and the physical environment, to name a few. Operational factors include workload, staffing mix, degree of specificity, and availability of equipment/materials. Administration includes wage/salary benefits, performance appraisals, and philosophy of management.

External dimensions, which impact upon quality of worklife, include client demand on systems, health care policy, and the labour market. Client demands on the system consists of demographic changes, aging population, and technology. Health care policy comprises factors such as funding and delivery of care. The labour market environment includes regional variations and organization demands (O'Brien-Pallas & Baumann, 1992).

It is the interaction of all of these factors that influence quality of worklife for all health professionals. As an employer or manager, there are a number of the above-mentioned factors that can be addressed to influence the quality of the environment in which the individual works, therefore affecting the success of recruitment and retention programs. The literature suggests a number of strategies for improving quality of worklife:

- Health professionals have indicated enhancing jobs with heightened levels of autonomy contributes to job satisfaction and therefore a good quality of worklife (Davis & Bordieri, 1988; Oakerlund, Jackson & Parsons, 1994; Wolpert & Yoshida, 1992; Baumann et al., 2001).

- Management competence, management style, and employee participation have been identified as priorities when considering employee physical and mental health (Robson, Lemieux-Charles, McGuire & Cole, 2001). The leadership style of one's manager greatly affects the environment in which an individual works, and therefore the quality of worklife (Brollier 1985a, 1985b).
- Professional integration, the feeling of being integrated within one's own professional group and with immediate colleagues, affect the environment in which an individual is employed, and is another factor linked to worklife amongst health professionals (Collins, Jones, McDonnell, 2000; O'Brien-Pallas & Baumann, 1992).
- Adequate preparedness to carry out roles, role clarity and well-defined boundaries of practice are important in addressing operational factors influencing quality of worklife.
- Institutional policies encouraging promotional career laddering, performance appraisals and appropriate employee recognition (through recognition programs, salary and benefits, etc.) are methods that address administrative factors in worklife (O'Brien-Pallas & Baumann, 1992).
- Implementations of self-scheduling and/or flexible scheduling methods help employees gain a sense of control over their work environments (O'Brien-Pallas & Baumann, 1992).

There have been a vast and growing number of reports released over the recent years on this topic. Quality of worklife is a key component in recruiting and retaining health professionals, and also providing quality health services. The Canadian Council on Health Services Accreditation (CCHSA) has included worklife as one of four dimensions of quality in its Achieving Improved Measurement (AIM) Accreditation Standards. Therefore organizations that are currently undergoing or will undergo accreditation will be evaluated in the quality of the working environment that is provided to employees (CCHSA, 2001). The Canadian Health Services Research Foundation (CHSRF) has recently funded research around the benefits of healthy workplaces for nurses, "Commitment and Care: the Benefits of a Health Workplace for Nurses, their Patients and the System" (Baumann et al., 2001). Magnet Hospital research in the United States also concentrates on the quality of worklife for nurses, and the benefits of a positive work environment on staff and patient outcomes (Scott, Sochalski & Aiken, 1999). These are just a few of the resources available describing the importance of quality of worklife, and therefore successful recruitment and retention.

2.1 Allied Health

A report entitled 'The Impact of Health Care Reforms on Allied Health Professionals: Summary of Findings' (Way, Pond, Gregory, Barrett & Parfrey, 2000) examined work-related attitudes of allied health professionals working in selected acute care settings in Newfoundland and Labrador. The report was based on a survey response rate of 61 percent. The following are findings related to worklife issues:

- Fifty-eight percent of respondents reported that they were satisfied with their jobs. Eighty-four percent reported that they were generally satisfied with the kind of work they do in their job.
- Only 34 percent of allied health respondents agreed that co-workers were satisfied with their jobs.
- Seventy-three percent of respondents did not feel that they received recognition and appreciation for their work.
- Only 38 percent of respondents were satisfied with the degree to which management sought input on professional standards of care.
- Sixty-three percent of respondents reported that increased demands and stress led to unpleasant working relationships with both co-workers and other health care providers.
- Most allied health respondents reported that clients did not have reasonable access to health services (70%) and that resources/supplies were inadequate in ensuring client comfort (84%).

2.2 Nursing

A review of the literature reveals a rapid increase in the number of articles and research studies examining worklife issues for nurses. Baumann et al. (2001) recently released the results of their large Canadian synthesis study on working environments.

Recommendations in this report were broken down into those for government, professionals associations and councils, employers, and educators and researchers, suggesting approaches to improving working conditions. It is noteworthy that several of the recommendations in this report are already in some workplaces in this province such self-scheduling, equitable salaries for community nurses, and funding for nurse practitioner positions to name a few. A complete list of these recommendations is found in Appendix A. Nationally, absenteeism in nurses rose from 6.8% in 1986 to 8.5% of the nursing workforce in 1999, and has become a major expense for the health system (Baumann et al., 2001). Restructuring has also restricted nurses' employment choices, career mobility and career plans (Baumann et al., 2001).

A study comparing satisfaction levels amongst RNs in acute care hospitals in five countries found that, in all countries combined, most RNs were satisfied with their jobs. RNs from Germany appeared to be most satisfied, while RNs from the United States were least satisfied. Canadian RNs participating in the survey fell in the middle, with 67% indicating they were satisfied with their job (Aiken et al., 2001). A later study by Statistics Canada, surveying a broader range of Canadian nurses, found that only 13% of nurses were dissatisfied or very dissatisfied with their current job (CIHI, 2001-a).

Further studies on the health of nurses in Canada are also emerging. “The Nursing Strategy for Canada” (ACHHR, 2000) identified quality of worklife as a major focus area in their report. One recommendation was the creation of a Canadian Nursing Advisory Committee that would be established with nursing stakeholder representatives from throughout the country. It will produce a report in 2002. Magnet Hospital research, largely from the United States have trended characteristics of model work environments for many years (Lewis & Matthews, 1998).

Reports entitled ‘The Impact of Health Care Reforms on Registered Nurses: Summary of Findings’ (Way, Baker, Chubbs, Davis, Gregory, Barrett & Parfrey, 2001) and ‘The Impact of Health Care Reforms on Licensed Practical Nurses in the Acute Care Setting: Summary of Findings’ (Way, Gregory, Pond, Barrett, & Parfrey, 2000) examined RNs and LPNs attitudes respectfully following restructuring of the health system, and generated a database on work-related attitudes of those working in the acute care setting in Newfoundland and Labrador. The reports were based on survey response rates of 34.1% for RNs and 37.8% for LPNs.

There were numerous findings in these studies related to worklife issues such as:

- Both RN and LPN respondents found their jobs less satisfying and challenging since restructuring of the health care system (92% and 83%, respectively),
- Eighty-one percent of RNs and 78% of LPNs reported that they did not feel they were recognized or appreciated for their work;
- RN and LPN respondents reported unpleasant working relations with co-workers and other health care providers 76% and 74% of the time, respectively;
- Forty-five percent of RNs reported that absence of a supportive environment prevented them from giving that ‘extra’ effort when their job demanded it; LPNs felt that they were able to give that extra effort when their job demanded it (67%);
- Respondents reported that management did not meet regularly with staff to discuss workplace concerns (54% for RNs and LPNs) or identify ways to resolve problems and build on strengths (63% for RNs and 58% for LPNs);
- Most RNs and LPNs did not believe that there were adequate resources/supplies to ensure patient comfort (77% and 72%, respectively); a majority of RNs reported that they did not believe it was possible to meet patients’ basic care needs (57%);
- Seventy-three percent of RNs and 81% of LPNs were very satisfied with the type of work in their jobs; 45% of RNs and 65% of LPNs indicated that they were satisfied with their jobs, but only 24% and 37% believed that their co-workers were satisfied with their jobs;
- RNs were somewhat dissatisfied with the interdisciplinary approach to patient care (53%) and the time spent on interdisciplinary conflicts (69%); LPNs indicated satisfaction with the interdisciplinary approach to patient/client care (66%) and the amount of time spent trying to resolve interdisciplinary conflicts (53%);

- RN and LPN respondents were dissatisfied with the visibility and accessibility of management since restructuring (69% and 53%, respectively), with the degree to which management seeks input on professionals care standards (70% and 60%, respectively), and the amount of information/in-service provided to help prepare staff for restructuring related changes (70% and 57%);
- Eighty-eight percent of RNs and 75% of LPNs felt that the amount of rewards received was much lower than their expectations;
- Fifty percent of RNs and 70% of LPNs indicated that they would likely stay with their current employer, but 37% and 32% of RNs and LPNs, respectively, indicated that they were unsure;
- Fifty-three percent of RNs said that they would leave their current positions if another employment opportunity presented itself, but only 35% of RNs and 39% of LPNs had seriously engaged in job search activities; 40% of LPN respondents considered leaving their current position if another employment opportunity presented itself.

These results generally reflect a workforce experiencing frustration and low morale. RNs and LPNs expressed a preference to be more involved in the planning and future development of the delivery system and felt lack of consultation and communication during recent periods of change. Areas of dissatisfaction were noted in relation to interdisciplinary practice, availability of the resources and supports needed to do their job well, and generally stressed interpersonal relations with colleagues.

2.3 Physicians

In September 1999, the Patient Research Centre carried out a survey of physicians working in the province to evaluate physicians attitudes following restructuring of the health system and to generate baseline data on physicians' work-related attitudes so they could be monitored over time (Gregory, Way, Barrett & Parfrey, 2001). The target population was all physicians employed in this province. The responding sample was 51% General Practitioners, and 49% specialists. There were also an equal number of hospital-based (40%) versus hospital and office based (40%) practitioners. The following is a summary of the findings from this report, entitled "The Impact of Health Care Reforms: Physician Perceptions" related to quality of worklife (other findings will appear in the relevant sections of this report):

- The majority of respondents (64%) did not believe that there were sufficient resources available to support their practice requirements, or that physicians had a significant voice in shaping restructuring initiatives so as to minimize detrimental effects on medical practice and/or patient care (77%).
- Physicians perceived the overall impact of health reforms more positively than RNs, but more negatively than management.
- Seventy percent of respondents felt frustrated with the reduced level of care being provided due to increased workloads, did not find their jobs more satisfying and challenging since restructuring (88%), and believed that increased demands and stress in the workplace had created a sense of disillusionment and low morale (87%).

- Only 46% of respondents felt that management met regularly with staff to identify ways to resolve problems and build on strengths.
- Most physicians (84%) believed that supplies/resources were inadequate to ensure patient comfort.
- While most respondents (64%) believed that the necessary physical resources were available to provide safe care, only 37% of respondents believed that there were sufficient human resources available to do so.
- Seventy-nine percent of respondents indicated that they were very satisfied with the type of work in their jobs.
- Just over half of respondents (51%) indicated that they would stay with their current employer, and 59% had not seriously engaged in job search activities.

2.4 Management

Restructuring of the health system has resulted in significant role changes for managers in the system, and it has been suggested that if managers do not receive sufficient support while adapting to their new and additional roles and responsibilities, this could lead to greater job dissatisfaction, and reduced organizational commitment (Way, Davis, Gregory, Barrett & Parfrey, 2000). “The Impact of Health Care Reforms on Management Personnel” examines the impact of restructuring on managers in acute care hospitals in three provincial health boards in Newfoundland and Labrador. The purpose of the study was to investigate the attitudes of managers in the system following restructuring, and to generate a baseline of managers’ work-related attitudes, so they could be monitored over time. It should be noted that managers in the long-term care and health & community service sectors were not included in this study. The following is a summary of the findings from this report related to quality of worklife.

- When examining perceptions of reform, workplace issues, quality/safety concerns, and overall impact of reforms, the managers in the health system rated each more positively than those obtained from comparison groups (i.e. RNs, LPNs, and allied health professionals).
- Most managers (51.7%) felt frustrated with the reduced level of care being provided due to increased workloads.
- Fifty-two percent of managers did not find their jobs more satisfying since restructuring of the system, and 67% believed that increased stress and demands in the workplace created unpleasant working relations with co-workers and other health care providers.
- Seventy-two percent of respondents did not believe that there were adequate supplies/resources to ensure patient comfort.
- Ninety percent of managers who responded believed that agency procedures were being performed in a safe and competent manner, and that the necessary physical (82%) and human (64%) resources were available to provide safe care.
- Managers were significantly more satisfied with and committed to their jobs than other provider groups.
- Most respondents (66%) indicated that they would likely stay with their current employer, and had not engaged in job search activities (62%).

Anecdotal evidence suggests that employees in the provincial health boards are hesitant about moving into management positions for reasons such as increased workload, a lack of support in the workplace and inadequate financial compensation.

2.5 Recommendations

Recommendation

- 1. In workplaces where there is little opportunity for change, rotating exchange employment opportunities be investigated as a means for which to permit health professionals opportunity to work in an alternate setting for a selected time period either within the current board or with another board.**

Details

Such a program could include enrichment opportunities available on a rotational basis, which would provide opportunities to identify management potential and clinical expertise in the health system.

The following should be considered when investigating such an exchange program:

- Financial incentives attached to 'hard-to-recruit' regions of the province,
- The potential of such a program to draw people from rural regions of the province into main centers, further impacting recruitment challenges in rural regions of the province,
- Willingness/interest on the part of professionals to participate in such a program,
- Travel/accommodation costs,
- Cost associated with orientating professionals to new positions, areas, etc., and
- Flexibility on the part of unions and employers.

Current Status

Collective agreements allow for members to apply on any vacancies and/or new positions in their employing organization, giving them the opportunity to change/rotate through positions, programs, etc.

Recommendation

- 2. Health boards' staff further develop health promotion, prevention and wellness programs, sharing best practices with other boards.**

Details

Such programs could include:

- Opportunities for morale building and professional integration,
- Health promotion, prevention and wellness education,
- Means in which to promote employee wellness, i.e., discounts/reimbursements on fitness membership fees, seminars on wellness in the workplace, Employee & Family Assistance Programs, etc.

Current Status

All health boards have individuals or departments whose responsibility or focus is employee wellness. The comprehensiveness of such programs varies throughout the boards.

3 Workload/Skill Mix Issues

As discussed in the previous section, operational factors such as workload and skill mix have an impact on the health professional and the environment in which he/she works (O'Brien-Pallas & Baumann, 1992).

The workload of health professionals has been raised as a significant issue in the health system, and is of concern to the majority of health professional groups. Environments with consistently high workloads impact upon the retention of professional groups as workload has been shown to be associated with job satisfaction and burnout (Siefert, Jayaratne & Chess, 1991). A reasonable and manageable workload has been identified as a key element in decreasing turnover, increasing retention and increasing productivity (Grant, 1982). While increased workloads may increase short-term productivity, they increase long-term costs through development of stress-related illness, and poor judgment calls possibly leading to patient harm, to name a few (Baumann et al., 2001). The relationship between recruitment, retention and workload has been cited repeatedly throughout the literature when considering the health professions (Freda, 1992; Bailey, 1990a). For example, Warnecke (1991) found that high patient – therapist ratios was one of the top 10 priorities influencing the job choice of Occupational Therapists.

The challenge in this area has historically been the ability to measure workload comparably, reflecting patient acuity and environmental considerations. Further to this, generally there are no national standards for workload for most health professionals. Variables such as patient acuity and functional independence, work environment, support systems, technology and skill/experience level of the practitioner all contribute to a complex group of workload determinants. Systems, such as Management Information System (MIS), have been in place for many years, yet consistency and compliance in reporting remains a challenge. Education of health system managers, senior administrators, professional associations, unions and other decision makers concerning the collection of workload statistics, interpretation of the statistics, and how they can be used for planning purposes is essential in ensuring consistency and compliance in reporting of workload.

In attempts to reduce health system costs, and increase efficiency, “(t)here is a growing trend toward lowering the skill and professionalism of bedside caregivers” (Shamian & Lightstone, 1997, p. OS66). The result of introducing these new groups of caregivers is decreased role clarity, and increased blurring and overlapping of roles amongst the various health disciplines (Shamian & Lightstone, 1997). Health professionals can interpret the introduction of this type of support in one of two ways – as a threat to their traditional role, or as an opportunity to refine their role and realize true potential in the system (McDonald, 1998).

The lack of regulation of some groups and inconsistency in educational programs contributes to the lack of clarity of roles, at times. Clearly defining and communicating the role of alternative and complementary caregivers, education about roles, instruction in supervision and delegation for professionals, and leadership commitment in making the relationship work, can aid in making health professionals more satisfied with their redefined role in the workplace. As discussed in the previous section, role clarity and well-defined boundaries of practice are important in addressing operational factors such as workload and skill mix, are essential in facilitating a positive work environment, and therefore the successful recruitment and retention of health professionals (O’Brien-Pallas & Baumann, 1992). There are many examples in the Newfoundland and Labrador health system where such complementary roles and relationships exist, such as RN-LPN, LPN-PCA, Pharmacist-Pharmacy Technician, OT-OT Assistant, General Practitioner-Nurse Practitioner Primary Health Care.

3.1 Allied Health

While workload for allied health professionals is generally measured by examining service recipient activities and non-service recipient activities, and by calculating caseload and activity statistics, there are factors beyond absolute numbers that impact workload. These factors can be separated into professional and provincial issues:

- Professional Issues
 - The work of many allied health professionals does not lend itself to casual or relief staff. This lack of relief increases volume, wait times, and wait lists following periods of annual or sick leave, and also increases workload for those professionals providing cross-coverage while a colleague is away from their regular duties.
 - There is growing recognition by allied health professionals that alternative and complementary providers can assist in improving client services. Roles such as pharmacy technicians, OT assistants, and respiratory therapy technicians allow the allied health professional to focus their efforts on the area of expertise. These providers are not always available in many areas of the province, therefore requiring much of the support work to be completed by the allied health professional.
 - Lack of access to technology in the form of computer support can increase workload as can the lack of clerical support requiring allied health professionals to spend time at clerical duties.

- Some licensing bodies will not permit new graduates to work in sole practice. Often, new graduates are recruited into positions in rural regions of the province, where they are sole practitioners. Access to mentors through technology, as a means of support to the new practitioner, may provide a way of satisfying licensing requirements.
- Regarding standards of care, 79 percent of allied health professionals surveyed in “The Impact of Health Care Reforms in Allied Health Professionals” stated that there were lower professional standards due to work demands and 75 percent felt frustrated with the reduced level of care provided due to workload demands. Eighty-two percent felt that the demands and stressors placed upon them increased the potential for harm to clients/patients (Way, Pond, Gregory, Barrett & Parfrey, 2000).
- Provincial Issues
 - There is a lack of sufficient resources to accommodate the demand for community and outpatient programs. With this gap in the continuum of care, there are limited sources for referral in some areas, and for some professionals. Therefore individuals get admitted to institutions though it is not medically necessary. For example, the Rehabilitation Program in one health board has found over the last four years that an average of 31% of admissions could have been handled on an outpatient basis. There has been insufficient outpatient or community allied health resources to accommodate these clients (J. Squires, personal communication, August, 2001).
 - The availability and funding for alternative and complementary allied health roles are inconsistent within the health boards.
 - Training for alternative and complementary allied health roles is inconsistent or lacking for some allied health support roles in this province.
 - Shifting demographics with an increasing number of elderly individuals has created a higher demand for health services in this age group. The decline in the population of younger age groups has had the opposite effect for some services. Overall, resource demands are increasing.
 - Geography affects the percentage of direct service a professional can deliver, as the larger the area, the greater the issue of travel time, and therefore the percentage of time spent in non-service recipient activities. Rural areas where sole practice positions are more common are of particular concern. Weather conditions and travel issues add to the challenge.
 - There is a need to consider where services are located, as some regions of the province require a higher proportion of allied health professionals per population due to specific needs in the population/region and the availability of secondary and tertiary services.

- Restructuring of public sector systems has led to some allied health professionals taking on more administrative duties in addition to clinical work. A new generic system of collecting workload data was introduced in the mid-to late 1990's, making pre- and post-restructuring comparisons impossible, however within continued attention to the collection and quality of workload data, such comparisons will be possible in the coming years.
- The majority of allied health professionals have perceived the move towards community-based care as positive. Funding for prevention programs remains a concern as lack of prevention impacts upon acuity of problems when clients reach the acute care systems.
- In areas where there are chronic shortages and vacancies, health professionals face greater workload pressure in efforts to meet demand, and public complaints due to decreased access to services. The Human Resource Employer Indicator Report (2000) indicated that turnover rates within the permanent and temporary professional groups examined, were greatest for allied health professionals in health boards. They ranged from 12% for pharmacists and speech language pathologists to 37% for physiotherapists (Provincial Health and Community Services Human Resource Planning Committee and Sub-Committees, 2000).
- Clients are presenting with more complex problems than ever before. In a membership consultation survey completed by the Newfoundland and Labrador Association of Social Workers (NLASW), 87 percent of social workers were concerned about the increasing complexity of caseloads. A formal review of workload is currently underway for health and community services social workers.
- CIHI (2001-b) reported changes in population to professional ratios. In this province, many allied health professional groups have higher population to professional ratios than the national average. The population per health professional figure is a means of measuring expansion or reduction in a health professional group. This figure is not an indication of whether there are sufficient or insufficient numbers of health professionals within a particular population (CIHI, 2001-b). Table 1 examines provincial and national population per professional ratios for a number of groups.

Table 1: Provincial and National Population per Professional Ratios

Professional Group	Provincial Population per Professional Ratios, 2000	National Population per Professional Ratios, 2000
Dietitians	4372	4499
Licensed Practical Nurses	185	423
Occupational Therapists	3926	3255
Pharmacists	1046	1259
Physicians	580	534
Physiotherapists	2702	1967
Psychologists	2758	2334
Registered Nurses	100	133

Source: CIHI 2001-b

3.2 Nursing

Nationally, discussions on workload, staffing levels, and skill mix remain prevalent. Nursing workload measurement tools, while used in health service delivery for over two decades, remains an area of debate in terms of comprehensively reflecting the full dimensions of the profession. Numerous tools are available and in use both nationally, and in this province, primarily in acute care settings.

Significant numbers of nursing positions were removed from the health care system nationally in the mid 90's in response to shrinking health care funding. Bauman et al. (2001) stated that restructuring meant that there were fewer to care for more, and sicker, patients. They further concluded that nurses in community and long-term care settings faced greater demands due to technological advances allowing patients to move into these settings following shorter hospital stays (Baumann et al., 2001). While there were few nursing positions lost in this province and reportedly no decrease in length of stay, loses in some support positions and management roles was felt by many to have resulted in greater workload for nurses in some areas.

Perceptions of RNs and LPNs workload were examined in the Provincial reports (Way et al., 2001; Way et al., 2000) revealing:

- Sixty-two percent of RNs reported that the staffing situation was inadequate to meet patient needs;
- Seventy two percent of RN respondents indicated that casual RNs or callbacks were often needed to bring the staff/patient ratio up to adequate levels;
- Forty-eight percent of RN respondents reported that they have been ordered back to work on their days off, 56% of RNs have had annual leave requests denied, and 88% of respondents reported missing breaks;
- Eighty-one percent of RNs and 84% of LPNs reported frustration with the reduced level of care being provided due to increased workloads;

- Only 42% of RNs and 60% of LPNs indicated that the necessary human resources were always available to provide safe care; RNs reported that adequate teaching and counseling is being provided to patients and their families prior to discharge 31% of the time, and adequate human resources were always available for patients following hospital discharge 17% of the time;
- Eighty-six percent of RNs and 76% of LPNs felt that patients are more susceptible to potential harm from errors or delays due to increased demands in the workplace;
- RN and LPN respondents reported that it was necessary to lower professional standards due to overwhelming workload demands (85% and 72%, respectively).

Overall these findings validate a perception by RNs and LPNs that workloads in these acute care settings are excessive in many cases. There are no data available however to adequately measure this workload comparatively across sites or units. Workload measurement tools are not used consistently across sites or Health Boards making comparisons difficult. This is an area in need of further research as workload measurement tools improve.

In this province, RN/LPN ratios and LPN scope of practice varies across settings. Efforts to standardize staffing patterns in the province has resulted in changes to staffing levels and skill mix in some health boards. However, since LPN scope of practice varies significantly depending on the practice setting, patient acuity, historical work patterns and varying educational preparation of LPNs (i.e. graduates from the revised curriculum vs. the older curriculum), standardized staffing is often challenging. Newfoundland and Labrador, unlike other jurisdictions, has almost complete professional nurse staffing (RN and LPN), with the highest number of LPN per population (5.4 LPNs per 1000 population) and RN/LPN ratio in Canada (5.4 LPNs per 10 RNs) (CIHI, 2001-b). The use of unregulated workers is much more widespread elsewhere in the country.

With the purpose of addressing issues around scope of practice and RN/LPN skill mix, a provincial 'Learning Circles Project' was developed. The goals of the project include an enhanced collaborative environment for RNs and LPNs, increased awareness of nursing practice-guiding principles, a greater understanding of professional roles and competencies, improved decision making skills, and enhanced value and respect for RN and LPN contributions to client care. Such a project aids in clarifying roles in the workplace, and understanding the contribution each professional group makes to the health system.

3.3 Physicians

Issues and concerns related to workload of physicians are evident by both recent research as well as public debate. Workload standards are not widely available however some specialty disciplines have moved forward in recommending caseload standards. The report "A Framework for Primary Care Renewal" prepared by the Provincial Primary Care Advisory Committee, December 14, 2001, referenced workload statistics for family physicians as reported by the College of Family Physicians of Canada in October 2001. 'The average duration of service that is provided by a primary care physician in this

province is approximately 62 hours per week (excluding call). 80% of physicians in this province perform on call. This adds up to 25 hours to the work week, extending it to 87 hours.” (LeGrow, 2001) Skill mix issues are relatively new as well in physician human resource planning as it relates to ratios of physicians to other professions. There is little research in this area to date.

The following are examples of some findings from the report “The Impact of Health Care Reforms: Physician Perceptions” (Gregory, Way, Barrett & Parfrey, 2001) related to workload/skill mix issues:

- Seventy-six percent of respondents reported experiencing a change in their patient workload since restructuring, with 67% indicating an increase in workload.
- Most (82%) respondents felt that patients were most susceptible to potential harm from errors or delays due to increased demands in the workplace.
- The majority of respondents (61.3%) did not experience a change in on call requirements since restructuring.

3.4 Management

Few studies have been conducted to date that adequately explore issues of workload/skill mix for managers. Anecdotal evidence for those who have been in the health system management area for the last decade suggests managers feel workload has increased. The diversity and scope of management responsibility has also reportedly increased requiring a typical manager to be responsible for several units/departments with different mandates, different professional staff groupings as well as multiple geographic sites at times.

The study “Impact of Health Care Reforms on Management Personnel” (Way, Davis, Gregory, Barrett and Parfrey, 2000) did not report findings specifically related to workload. No established tools for measuring workload of management are currently in use in the health system. A current study underway through the Human Resource Sector Study has focused on managers work profile. Findings will offer insight into the work patterns for health system managers in Newfoundland and Labrador.

3.5 Recommendations

Recommendation

- 3. Funding of demonstration projects in selected areas of the province to test best practices in creating workplaces that support excellence in clinical practice, leadership, scope of practice, a collaborative work environment, and quality health services.**

Details

The design of the program should be based in research to date around quality of worklife, and may include mentorship programs, orientation, scheduling and

secretarial/therapeutic/technical/clerical/management support. It is essential that test sites undergo pre-assessment (including staff and client satisfaction), in order to ensure appropriate evaluation is feasible upon project completion. Upon project completion, there should be global dissemination of demonstration project results.

Current Status

Learning Circles Project

With the aims of enhancing the practice environment and working relationship between RNs and LPNs, the ARNNL and CLPN implemented a Learning Circles Project. Using the Learning Circles conceptual framework, a two-day training session was developed for direct care RNs and LPNs. Within this framework, practitioners learned specific skills to enable them respond to scope of practice issues and build more collaborative working relationships. More information on the project and its evaluation can be found in the 'Association of Registered Nurses of Newfoundland and Labrador and the Council for Licensed Practice Nurses Learning Circles Project: Final Report' (2001).

Primary Health Care Enhancement Project - 1997

In response to the Provincial Forum on Health Care, the Department of Health and Community Services and a number of provincial health organizations initiated the establishment of three pilot projects aimed at strengthening primary health care services in three rural communities in Newfoundland and Labrador. Based at Port aux Basque, Twillingate and Happy Valley-Goose Bay, the purpose of these Rural Primary Health Care Service and Teaching Units was to improve the recruitment and retention of health care professionals by reducing professional isolation, providing greater opportunities for continuing education and interdisciplinary education, and providing improved working conditions for rural health care providers. The introduction of telehealth technology at these sites was introduced to overcome geographical barriers, to promote remote consultation, diagnosis, and the continuing education of health professionals.

4 Professional Development

Professional development is a broad term referring to a continuum of educational elements that cross the entire career trajectory for all health professional groups. It includes development opportunities on the informal ad hoc end of the spectrum and ranges up to advanced academic achievements. It also includes career laddering and long-term as well as short-term career goals. Each is essential to the ongoing competency maintenance, specialty development, professional self-aspirations, and overall growth of the profession at large in the health sector. Such professional development opportunities have been limited for most health professionals in the publicly funded system in Newfoundland and Labrador for many years.

Professional development has a two fold benefit to the public, health organizations and professionals themselves; it promotes public services that are atoned to the latest developments and research in the discipline, and it is a strong recruitment and retention element that ensures services are maintained. Professional associations, unions,

employees and managers have recognized the importance of professional development and have lobbied for attention to this factor for many years, with limited successes.

The Conference Board of Canada, in its sixth edition of the report *Training and Development Outlook* (2001), summarizes the results of a survey sent to 1800 Canadian organizations. One hundred seventy-four organizations participated in the survey, representing medium and large sized organizations across Canada, including all major industries in the private sector, crown corporations, government departments, educational institutions and hospitals. The following represents key findings related to health outlined in the report:

- When compared to all organizations surveyed, those in the health/education category report the lowest training investment per employee, at an average of \$240 per employee. The average expenditure per employee across all industries was \$859.
- While overall, survey respondents indicated that a majority of employees (72%) received formal training in 2000, significantly fewer employees (< 50%) in the health/education sectors received formal training when compared to other industries.
- Overall average expenditure on training and development in all sectors in Canada was 1.8% of payroll in 2000. Health/education spent 0.6% of payroll on training and development in the same year.

Throughout the six conference board surveys, the health/education sector has consistently remained the lowest spender on training and development, following such industries as technology/communications, government, and wholesale/retail trade (Harris-Lalonde, 2001). Training and development costs compared in the survey included:

- Wages and salaries of all full-time internal training staff (e.g. those who spend all of their time in training related activities);
- Wages and salaries of part-time internal training staff;
- Payment to outside trainers or companies that provided training;
- Tuition reimbursement;
- Expenditures on electronic hardware or software used to deliver information and facilitate the development of skills and knowledge; and
- Other training expenses (e.g. training facilities expenses, payments to a parent company for training, internally produced course materials, catalogues and internal marketing, travel expenses for training staff and training administration costs).

Note, Conference Board of Canada comparative costs excluded:

- Wages and salaries of those participating in training;
- Travel expenses of training participants;
- Wages and salaries of employees who may provide training, but it is not their primary function in the organization; and
- Costs of participants' conference attendance fees and travel.

No national data or benchmarks are available for these development costs.

The nature of professional development and continuing education in the health sector necessitates both internal resource allocations in addition to funding for external opportunities. Due to the specialized nature of some professional practices, attendance at external provincial or national educational events is required to maintain contact with peers and facilitate the dissemination of emerging knowledge and research. Relief costs are also a significant factor when considering professional development opportunities in the health sector. The health sector is expected to continue to operate and provide services to the public 24 hours a day, seven days a week. Relief has to be coordinated in some departments so that those attending the workshop, conference, session, etc. can be replaced. This also has implications if a workshop is being provided internally for all staff because numerous sessions have to be coordinated to accommodate all staff and ensure the organization maintains its' level of service, and that those who work outside the nine-to-five workday have the opportunity to attend.

Access to continuing education and professional development opportunities have been linked to job satisfaction. It is suggested in the literature that continuing education opportunities be included in a recruitment and retention program (Okerlund, Jackson & Parsons, 1994; Wolpert & Yoshida, 1992). The opportunity to participate in professional development is thought to be important in “instilling, maintaining and fostering professional satisfaction, commitment, confidence, empowerment and subsequently quality of care” and the health of human resources (Government of Manitoba Worklife Task Force, 2001).

4.1 Allied Health

Allied health professionals have long articulated their concerns with lack of sufficient professional development opportunities. It is particularly difficult for those allied health professionals who are not trained in the province or who are working in rural regions to participate in professional development, largely because they are not situated near centers of excellence that would provide such opportunities. The following realities relate to professional development for the allied health professions.

- In a January 1996 “Survey of Human Resources for Occupational Therapists, Physiotherapists, Speech Language Pathologists, Audiologists, and Recreation Therapy Practitioners” commissioned by the Department of Health, all groups except Recreation Therapists identified opportunity for professional development and continuing education were minimal. There is little evidence of any growth in funding or opportunities for professional development since the time of this survey.
- As the Health Boards manage increasing deficits, the need to reduce such deficits has caused continuing education budgets to be cut.
- Most allied health groups in the province are trained outside the province. While a number of professional schools have Internet programs that providing linkages to these professional centers of excellence, many professionals do not have access to the Internet, and are therefore at a disadvantage in being able to access people, groups and research relevant to their profession.

- Several allied health groups are small (i.e. Audiology, Speech-Language Pathology) and have limited resources or critical mass to sustain active professional development on a provincial level. Resources available within health boards have been very limited to fund practitioners to attend continuing education or professional development opportunities outside their region, especially outside the province.
- Few opportunities available in the province that address discipline specific professional development. Educational offerings are often generic in nature.
- Mandatory continuing education requirements are in place as part of the licensing requirements for some allied health professional groups. These include social work, pharmacy, audiology, and speech language pathology.
- Peer consultation and informal development opportunities are absent in many regions, as the number of professionals per discipline is very low, with several incidences of sole practice. These work place realities indicate an even greater necessity to ensure professional development opportunities are available.
- Allied health professionals have experienced deterrents to their efforts to undertake professional development and continuing education in that employers often deny leave requests.
- Career laddering and opportunities for advancement are very limited in the regions of the province where the number of professionals per discipline is low, adding to the difficulty in recruitment and retention, and impacting on the level of job satisfaction.
- Allied health professionals and managers have expressed concerns with lack of library or journal resources, lack of Internet access, and overall feeling of intellectual isolation from their peers.

4.2 Nursing

Way et al. (2001) and Way et al. (2000) reported 47% of RNs and 57% of LPNs felt that they were being provided with opportunities to keep current with the latest developments. Other reports indicate that with current staff shortages, attendance at educational sessions is difficult, even when they are offered (Baumann et al., 2001). This has been reported as well in this province from both staff and managers. Baumann et al. (2001) cite the lack of professional development and continuing education opportunities as significant deterrents to developing a quality work environment. The rapid progress of research and new developments required constant mechanisms to keep staff knowledgeable in latest findings and ensure safe competent care.

4.3 Physicians

Many of the same concerns raised by allied health groups are common to physician groups in this province. Many physicians work in settings with few peer colleagues in their discipline and opportunities for continuing education and professional development are insufficient. Typically large research forums and conferences are located out of province. Access on site is limited to CME teleconference sessions, rounds, selected journals and Internet access in some sites.

The following is a finding from the report “The Impact of Health Care Reforms: Physician Perceptions” (Gregory, Way, Barrett & Parfrey, 2001) related to professional development:

- Most respondents (57%) believed that opportunities were being provided to keep current with latest developments.

4.4 Management

Preparation to assume leadership roles in the Canadian health system has advanced considerably over the past two decades with the advent of several Masters in Health Administration programs. The Canadian College of Health Services Executives also strongly supports development programs for health system leaders. Despite these programs, there are still a large number of managers who enter management without having an opportunity to complete extensive preparation for such a role.

Continuing education opportunities have been limited for managers over recent years as well as funding to support it. The current study of managers in the health system in this province as previously mentioned, has examined managers perceptions related to access to professional development.

4.5 Recommendations

Recommendation

- 4. Government and Health Boards work toward a five-year plan to ensure a minimum of 0.6% percent of health system payroll be dedicated to training and development as per the inclusion criteria of the Conference Board of Canada.**

Details

It is recommended that 0.6% of payroll be reserved for training and development within the Conference Board of Canada definition as per the national health/education current benchmark. Based on the fiscal realities, aiming to achieve the 1.8% national average in the short term is not realistic, although some boards may be in a position to achieve this.

Current Status

Provincial health boards, professional associations and unions also have monies set aside, in varying degrees, to support professional development of their employees and members (summary provided in Appendix B). The percentage of payroll expenditures dedicated to training and development in the provincial health system is currently under review.

Recommendation

- 5. Government and Health Boards work toward a five-year plan to ensure a minimum of 0.4% percent of payroll be dedicated to other professional development priorities not included in the Conference Board of Canada criteria such as attending external conferences and workshops, specialty and advanced education, and improving access to research, information and colleagues provincially, nationally and internationally.**

Details

It is recognized no national benchmark exists for these professional development costs noted in this recommendation. The Committee will be assessing current expenditure in this area. As such, the 0.4% of payroll may be adjusted.

Such an initiative includes:

- Internet access and appropriate computer equipment availability to health professionals for the purposes of accessing professional academic and research information, as well as interacting with colleagues in other jurisdictions.
- Exploration of access to mentors through technology for those newly graduated practitioners who are practicing in areas where there is little or no access to professional colleagues/mentors.
- Subscription to and dissemination of professional journals and literature, promoting access to relevant reports and information. This could be achieved through funding of the Newfoundland and Labrador Health Knowledge Information Network (NLHKIN) at \$124,000 - \$150,150 annually. A letter outlining specifics of what can be provided to the Health Boards, and the cost of this initiative can be found in Appendix C. It should be noted that this NLHKIN summary does not include board hardware, and/or connectivity costs, and not all areas of the province have total connectivity.
- Journal clubs, telehealth discussion groups, writing articles for publication in local health newsletters, and other local area activities to promote interaction with other professionals and interdisciplinary team members
- Continue to pursue refinement of workload measurement systems and ways to more accurately determine appropriate workload.
- Linkages with academic centres to enhanced development opportunities for professionals.
- Where feasible, term-appointed provincial research chairs be appointed in alliance with the Centre for Applied Health Research, to facilitate conducting and disseminating professional research.
- Note that Conference Board of Canada criteria excludes wages and salaries of those participating in training, travel expenses of participants in training, wages and salaries of employees who provide training (where it is not their primary function), and cost of conference attendance fees.

Current Status

A summary of current initiatives and programs can be found in Appendix D. Further details related to current expenditures is being requested.

5 Financial Incentives

Financial incentives are another element making up the complex interwoven network of factors that influence recruitment and retention of health professionals. Significant gains in collective agreements in some jurisdictions throughout Canada in the last one to two years have made recruitment and retention more difficult for provinces such as Newfoundland and Labrador. Strongly related to this, on a more global front, is the balance of supply and demand for health professionals in both the national and international market. Governments have expressed concern over the rising costs of health care in light of large salary increases and inability to sustain the health system at such rapid costs escalation rates. Professionals argue, however, that many years of wage freezes have had their toll and they are only catching up on losses over these years. According to a Statistics Canada Labour Force Survey, the average weekly earnings of full-time health workers increased by 4% between 1997 and 2000. For those working full-time in non-health occupations, there was a 6.8% increase over this same period (CIHI, 2001-a).

Changes in the structure of the health system have presented unique financial challenges in the recruitment and retention of health professionals. This competitive financial environment arises from two fronts; first the provincial, national and international competition within the public sector, and second between the private and public sector both home and abroad. For example, most health professionals are paid the same salary, regardless of location within the province. This makes it challenging for rural health boards when trying to recruit professionals because they can offer nothing more in terms of salary than would be earned in an urban location. Psychologists and Speech-Language Pathologists find financial competition exists within various sanctions of the public sectors. Allied health professionals in the public education system are sometimes perceived to have improved benefits when compared to the health sector.

In addition to wages, benefit packages, financial incentives and purchase of service arrangements are commonly used to recruit and retain professionals. The most commonly used methods have been bursaries, seat purchase, and relocation assistance. Others have included items such as comprehensive health benefit plans, housing allowances, travel allowances, continuing education allowances, payment of professional fees, and scaling up of salaries. Retention bonuses are also used, but are less common. While such methods are important, and often necessary short-term solutions to human resource concerns, they do not address the issues at their core. In order to retain qualified health professionals in such a financially competitive environment, it is necessary to include opportunities for career advancement, professional development, flexible work schedules, and organizational policies and programs that promote loyalty and retention (Aiken et al., 2001).

5.1 Allied Health

Financial incentives are not the only element in recruitment and retention of allied health professionals however they have a very powerful influence on the success of such efforts. Chronic vacancies and high turnover suggest that the influences of such incentives are significant. Labour force trends suggest national shortages will continue and grow further with the aging of the population and the aging of the workforce itself. Remaining competitive and creative in incentive approaches will be essential in addressing such impending shortages.

- At present, almost all allied health professionals in the public funded health sector in this province are paid lower salaries than their counterparts in other jurisdictions. For example, a Clinical Physiotherapist I in this province makes 8.5 percent less on average than their counterparts in other parts of Canada (Government of Newfoundland and Labrador, 2001).
- Added competition from a growing private sector within the province and abroad has added intense pressure to Health Boards trying to recruit and retain these groups. Health boards are already in a disadvantaged position in terms of being in undersupply, and recruiters have become very assertive and creative with financial bonuses and benefits to their recruitment packages. Travel, housing, ongoing bonuses, tuition, reduced hours of work, and high salaries are standard offerings, particularly by private employers and U.S. recruiters.
- A Treasury Board occupational review of selected health professionals in this province in 2000 resulted in improved salaries for the major allied health professional groups. Occupational reviews and reclassifications may reduce the out migration of allied health professionals in the short-term, however in the long-term, competition will continue to influence our ability to retain.
- Lack of professional schools for several allied health professions in this province has added to the difficulty in recruitment. There are no schools for occupational therapy, physiotherapy, speech language pathology, audiology, and clinical psychology, amongst others. Students graduating from universities outside this province are exposed to a greater array of employment and financial opportunities outside of the province. Newfoundland and Labrador has had success however in seat purchase and bursary programs for several decades. Recent students have expressed discontentment, however, with some elements of the seat purchase program. The retention evaluation can be found in Appendix E.
- Use of incentives varies across the province. These incentives are primarily initiated at the Board level and include such things as housing allowances in remote locations, relocation allowances, the Labrador Benefits Agreement package, and retention bonuses for social workers in remote Labrador locations, to name a few. Continuing education allowances are minimal, however professionals practicing in more rural and remote locations often times have greater access to funds than those in larger centres.

5.2 Nursing

Financial incentives are not the only element in recruitment and retention of RNs and LPNs, however they have a very powerful influence on the success of such efforts. One Statistics Canada survey found that about 67% of nurses were satisfied or very satisfied with their pay and benefits (CIHI, 2001-a). Nursing pay scales, however, have relatively few increments, and therefore there is little recognition for advanced clinical skills and expertise (Baumann et al., 2001). Labour force trends suggest national shortages will continue and grow further with the aging of the population and the aging of the workforce itself. Remaining competitive and creative in incentive approaches will be essential in addressing such impending shortages. Recruiters from outside the province have become very assertive and creative with financial bonuses and benefits to their recruitment packages. Travel, housing, ongoing bonuses, tuition, reduced hours of work, and high salaries are standard offerings, by other provinces, and international recruiters.

A recent reclassification of RNs and LPNs in this province resulted in improved salaries for these professional groups, however salaries remain less than their counterparts in many other provinces. For example, at the present time, a Nurse I in Newfoundland and Labrador make over 7 percent less on average than their counterparts in other provinces (Government of Newfoundland and Labrador, 2001). It is hoped that the reclassification that occurred in 2000 will reduce the out migration of RNs, however, longer-term competition will continue to influence our ability to recruit and retain. There are other incentives such as the bursaries that were available to new graduates in 2000 and 2001, northern recruitment and retention bonuses, housing allowances in remote locations, and relocation allowances, to name a few.

5.3 Physicians

Similar to the previous discussions for allied health professionals and nursing, most physicians' salaries have often been lower overall than their counterparts in other jurisdictions. Aggressive recruitment of graduates of physicians from residency programs as well as practicing physicians has created a very competitive environment both nationally and internationally.

Physicians in Newfoundland and Labrador have recently commenced MOU negotiations with government where detailed discussions on these matters will likely be priority. On call issues, incentives for rural and remote locations, as well as other similar concerns are commonly noted in negotiations in most jurisdictions. In an era when there is a national debate on alternative funding models, particularly in primary care, focus on financial issues will likely remain an area of considerable debate.

5.4 Management

One of the most significant issues raised by managers in the health system has been the salary compression experienced by front line clinical managers following the reclassification of several health profession groups in 2000. The Newfoundland and Labrador Health Boards Association have also been reviewing issues related to senior executives. Health boards report difficulty filling management positions in some locations and lack of financial incentive to move into management has been cited as one of the reasons. The management analysis underway by the health sector study will attempt to objectively assess some issues related to financial compensation for managers.

5.5 Recommendations

Recommendation

6. Competitive Atlantic Canadian public sector salaries and compensation.

Current Status

Health professionals' salaries are regularly monitored and compared to other jurisdictions throughout Canada and internationally by government, professional associations, and unions. Salary scales for certain health professional groups can be found in Appendix F.

6 Tools of Effective Recruitment and Retention

Currently, the Province of Newfoundland and Labrador is experiencing shortages in a number of health professions, causing some regions of the province to become under-serviced. A number of incentive and bursary programs have been implemented to help address the shortages. While such recruitment tools are short-term solutions, as once return-in-service agreements are met, professionals are free to leave the province/region; in some cases such incentives have led to long-term retention of professionals. It is also notable that the most successful recruitment has been with professionals originally from Newfoundland and Labrador, who have studied either in this province or abroad.

While insufficient financial compensation is often assumed to be the cause of recruitment and retention challenges, financial realities in this province make it impossible to compete dollar-for-dollar with most other provinces and countries. It is necessary to delve beyond the issue of salaries, into the use of other effective recruitment and retention tools that make an organization and/or region attractive for prospective employees.

When considering the four issues presented in this discussion paper – worklife, workload/skill mix, professional development and financial incentives – there are a number of strategies that can aid in the recruitment and retention of health professionals. Implementation of initiatives such as flexible scheduling and/or self-scheduling gives professionals a feeling of control over their work environment. Assurance of reasonable and manageable workloads, along with relief provisions makes an organization/region more attractive and helps in avoiding burnout. Availability of support, whether it be financial or in the form of time away from the workplace, to pursue professional development opportunities, has advantages for both the employee and the organization. Access to continuing education opportunities has been linked to job satisfaction, results in an environment in which professionals feel valued, and a workforce who are up-to-date with the latest research and developments in their profession.

Marketing is an important tool that can be used to promote the province and what it has to offer. A partnership between the Department of Health and Community Services and the Department of Tourism, Culture and Recreation could benefit and assist the recruitment and retention process of health professionals. Newfoundland and Labrador can offer a unique landscape and culture, clean air, and a safe environment in which to live – attractive lifestyle incentives for professionals with young families.

Demographics are important to consider when recruiting health professionals. Specific target groups can be identified and actively recruited. Each target group will possess personal attributes that will influence their preference to work and live in a particular location. For example, health care professionals today are not entering the workforce until their late 20's and early 30's (Peddle, 2001). For this reason, new employees often come with a spouse and children. Oftentimes, the professional's spouse is looking for employment and may also be graduating with significant debt-load. High debt loads are often a deterrent to staying within Newfoundland and Labrador because the province is not in a financial position to be able to be competitive with sign-on bonuses, retention bonuses and salaries. Since the province may be unable to compete financially with larger centers, an effective recruitment program for this demographic would include consideration of the family unit. Information about communities, schools, and employment opportunities, along with the financial support of bursaries and sign-on bonuses, could go a long way in attracting and retaining health professionals in this demographic group.

Young people today are faced with more employment options than ever before. The health services industry is often perceived as too highly regulated, low-tech, not financially rewarding, and not an environment in which they can maintain their autonomy and freedom (Manji, 2001). Health professionals have been very vocal and negative about working in the health system in recent years, also adding to the perceived unattractiveness of health professions. As a long-term recruitment strategy, professional associations and groups need to target school-aged children. By communicating to children the role of specific health professional groups, this may 'plant the seed' toward a career in health care. In one study, allied health professionals were asked to identify factors that were influential in their decision to pursue a career in their field, and the majority of respondents indicated that someone influenced them into looking into allied health as a career (Oakerlund, Jackson & Parsons, 1994). If professional groups find a means in which to communicate the positive aspects of working in the health system, and educate young people about opportunities in health, this may help in future recruitment, lessening shortages and recruitment challenges in the future. A noteworthy and positive finding at this time however, is the fact that the number of applicants for most health professional schools in Canada far exceeds the number of seats available, proving that individuals are still interested in pursuing careers in the health system.

Job fairs are another tool that organizations use to recruit professionals. They attract larger numbers of professionals to learn about the opportunities that are available to them. Job fairs enhance the possibility of recruiting individuals, but in order to do so effectively, it may be necessary to determine what specific professions to recruit through the development of a shortage and priority lists for both professions and areas of need.

A report entitled "Summary of Proceedings and Recommendations of the Provincial Physician Recruitment and Retention Coordinating Committee" released in February 1999 discusses and makes recommendations for consideration concerning physician recruitment and retention in Newfoundland and Labrador. The executive summary from this report can be found in Appendix G.

Implementing strategies such as exit interviews, which allow the employer to question an employees' motivation to leave the organization, provide insight into possible sources of dissatisfaction, so that they can be addressed. This strategy can help in identifying and addressing retention issues. Allowing student clinical placements in an organization introduce the student to the work environment. If the clinical experience is positive for the student, this may encourage their return upon graduation, making it a useful recruitment strategy. There is no specific lever that can increase recruitment and retention rates. A successful recruitment and retention strategy includes a combination of tools, as well as ongoing research into the development of new recruitment and retention initiatives that will help to address the challenges of the future.

6.1 Recommendations

Recommendation

7. The concept of a Provincial Health Professional Recruitment position(s) be explored.

Details

The following are possible functions of a provincial health professional recruiter:

- Implementation of a provincial web-site for recruitment, providing links to educational programs, health boards, and other relevant information;
- Development of marketing tools, including brochures, videos, etc. promoting the province, describing what Newfoundland and Labrador has to offer its residents, and professional opportunities for potential candidates;
- Act as a provincial representative at job fairs.

Current Status

There is currently a Provincial Physician Recruitment Coordinator employed by the NLHBA.

Recommendation

8. Bursary programs and retention bonuses be targeted at difficult to recruit professionals and locations throughout the province. These programs and bonuses should be reflective of difficulty of recruitment and retention across Health Boards, with attention paid to those locations where recruitment and retention of professionals is most challenging.

Current Status

A summary of the current provincially, government-funded bursary programs can be found in Appendix H.

7 Conclusion

As can be seen from the discussion, there is not one solution to success in the recruitment and retention of health professionals. It involves a combination of strategies that can be implemented through the provincial government, the organization itself, professional associations and unions. By taking steps to address quality of worklife, workload, professional development and financial incentives, health boards across Newfoundland and Labrador will become more successful in recruiting and retaining qualified health professionals.

8 Summary of Recommendation Options

The following summary of recommendation options, as identified in this discussion paper, have been made taking into consideration the literature review and findings surrounding the current work environment in Newfoundland and Labrador.

Recommendations

- 1. In workplaces where there is little opportunity for change, rotating exchange employment opportunities be investigated as a means for which to permit health professionals opportunity to work in an alternate setting for a selected time period either within the current board or with another board.**
- 2. Health boards' staff further develop health promotion, prevention and wellness programs, sharing best practices with other boards.**
- 3. Funding of demonstration projects in selected areas of the province to test best practices in creating workplaces that support excellence in clinical practice, leadership, scope of practice, a collaborative work environment, and quality health services.**
- 4. Government and Health Boards work toward a five-year plan to ensure a minimum of 0.6% percent of health system payroll be dedicated to training and development as per the inclusion criteria of the Conference Board of Canada.**
- 5. Government and Health Boards work toward a five-year plan to ensure a minimum of 0.4% percent of payroll be dedicated to other professional development priorities not included in the Conference Board of Canada criteria such as attending external conferences and workshops, specialty and advanced education, and improving access to research, information and colleagues provincially, nationally and internationally.**
- 6. Competitive Atlantic Canadian public sector salaries and compensation.**
- 7. The concept of a Provincial Health Professional Recruitment position(s) be explored.**
- 8. Bursary programs and retention bonuses be targeted at difficult to recruit professionals and locations throughout the province. These programs and bonuses should be reflective of difficulty of recruitment and retention across Health Boards, with attention paid to those locations where recruitment and retention of professionals is most challenging.**

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10 Appendix A: Recommendations from “Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system.”

Recommendations

In making these recommendations, the research team is envisaging a co-operative endeavour in which governments, professional associations and councils, employers, educators and researchers work to promote patient welfare by creating healthy nursing work environments that conform to the key points raised in this document.

Government

Support the welfare of nurses by:

- providing funds to increase nursing staff and support personnel so that managers can assign workloads that allow for how sick people are:
- ensuring that funding covers wages that are appropriate to the work required:
- ensuring that funds are dispersed across sectors so that community and long-term care organizations can offer equitable wages when competing for nursing personnel;
- re-evaluating practices, such as bidding for nursing services contracts, which may encourage cost cutting rather than good care;
- funding programs to create quality practice environments, provide incentives to maintain them and develop indicators to monitor them; and
- appointing chief nursing officers and advisory councils of nurses at federal, provincial and regional levels and

funding positions for advanced practice nurses and nurse practitioners.

Ensure the supply of nurses in the future by:

- encouraging ministries of health and ministries of education to work together on nursing education. (for example, ensure that positions are available to nurse practitioners if there are programs to train them);
- investing in continuing education, including baccalaureate and post-graduate programs; and
- promoting partnerships with stakeholders (employers, associations and educators).

Create a national database of key labour-market indicators to help forecast job demands.

Revise funding formulas to better support the many dimensions of nursing practice, set rules for using the funds and monitor how they are spent.

Funding strategies should include:

- creating mechanisms to minimize funding shortages that are caused by fluctuations in patient numbers;
- ensuring stable funding in order to permit long-term human resource planning;
- establishing contingency funds to cover the costs when specialized nursing needs arise; and

- addressing the time lag between applying for funding and receiving funds.

Fund research on indicators and models to monitor the health of nurses.

Professional Associations and Councils

Continue to work with employers to develop quality practice environments by:

- integrating healthy workplace principles into accreditation standards; and
- providing education and professional development opportunities to members (e.g., education on safety and violence awareness, leadership workshops)

Continue to be advocates for nurse and advise governments and employers through:

- identifying and informing stakeholders about trends in the nursing workforce;
- educating employers and human resource managers about the roles of nurses; and
- lobbying for legal and regulatory framework for nurses to practice to their full scope.

Have firm policies in place for dealing with abusive or violent behaviour.

Share recruitment and retention strategies and promote nursing through advertising and marketing strategies.

Employers

Address staffing issues by:

- hiring sufficient nurses to ensure a reasonable workload and addressing

issues of staff mix and full and part-time status;

- working with unions to develop flexible scheduling that suits both nurses and employers;
- employing support staff to reduce pressure on bedside nurses;
- assessing whether cost associated with use of agency personnel and overtime could be used for permanent full or part-time positions, including permanent float nurses;
- specifying nursing qualifications when hiring;
- having nursing units carry out hiring; and
- adopting the most effective tools for measuring and allocating workload.

Reward effort and achievement by:

- offering competitive pay and recognizing seniority through pay increments and benefits; allowing portable seniority;
- introducing clinical laddering and pay bands to recognize knowledge, skills and experience;
- recognizing and rewarding nurses who act as preceptors and mentors; and
- addressing quality-of-life issues by providing amenities such as child care, staff lounges, access to hot food and health programs.

Strengthen organization structures by:

- broadening board agendas to include the impact of policies on workers and patients;
- fostering an organizational culture that encourages strong nursing and multi-disciplinary teams through team-building and participatory decision-making;
- clarifying the roles of regulated and unregulated nursing staff; and

- establishing good communication between managers and staff.

Support nursing leadership and professional development by:

- integrating nurses into the organizational hierarchy through management positions, clinical laddering and meaningful participation in governance; and
- promoting latitude in decision-making related to nursing practice.

Promote workplace health and safety by:

- a participatory approach to workplace ergonomics;
- monitoring nurses health and
- providing a safe work environment with access to adequate and appropriate supplies.

Ensure that the work environment is a learning environment by:

- providing opportunities for education and the flexibility to allow staff to participate in educational activities;
- creating preceptorship and mentoring programs; and
- supporting performance evaluation.

Promote recruitment and retention by:

- trying creative job design (e.g., offer full-time graduates; protected mentoring time; flexible hours of employment for full pay);
- involving employees in recruitment and retention strategies; and
- working with educators to integrate new graduates into the workforce.

Educators and Researchers

Develop databases, workload-measurement and human-resources forecasting tools.

Do studies to evaluate the effectiveness of strategies to improve nurse's well-being.

In partnership with employers, governments and nursing associations, integrate new nurses into the workplace through strategies such as clinical internships and co-operative programs. Conduct environmental scans; identify strategies to increase efficiency, and improve the work environment, workforce health, and productivity.

Ensure a match between the curriculum and the skills required in the workplace; teach leadership skills, healthcare policy and work-place health issues for nurses.

Work with nursing association on scope-of-practice issues.

11 Appendix B: Professional Development Funding in the Newfoundland and Labrador Health Sector

Provincial Health Boards

The percentage of payroll expenditures dedicated to training and development in the provincial health system is currently under review.

Professional Associations

Newfoundland and Labrador Medical Association

- Does not have a continuing education fund for physicians.
- Have negotiated paid study leave for salaried physicians, paid by their employer.
- Award three scholarships – two \$1000 scholarships to two 2nd year medical students at MUN and one \$3000 scholarships to a fourth year student at MUN.
- Starting February 2002, will be awarding three \$1500 scholarships to medical students in Newfoundland-funded seats at MUN. These will be based on financial need.

The Newfoundland Association of Speech-Language Pathologists and Audiologists

- Two awards of \$750 for NASLPA members to attend an educational event.
- Six awards of \$50 for NASLPA members to attend the annual NASLPA Annual Meeting of Members and Conference help in the province.
- Awards are granted on a lottery system.
- Applications for the larger awards of \$750 must first be approved by the education committee and must include all details, including other sources of funding for the educational event.
- There is funding available via grants, loans or investments for groups of members to host an educational event – paid by way of the national association. Members must apply with a detailed financial plan and the event must benefit the majority of the membership.

Association of Registered Nurses of Newfoundland and Labrador

- \$250 - \$500 bursaries awarded annually for non-credit education programs such as workshops and post-basic courses, which enhance nursing practice.
- Other scholarships annually.
- Information is available on the ARNNL web-site (available at www.arnn.nf.ca).

Newfoundland Dietetic Association

- Do not provide funding for continuing education for members.

Newfoundland & Labrador Association of Social Workers

- In the last two years the NLASW has set up a professionals development fund of \$2000.
- The monies are awarded twice a year - \$1000 each time.
 - Members can apply to have the costs, or a portion of the cost of an educational event covered;
 - Applications are considered in a lottery whereby the 10 winners submit a receipt for their attendance and is reimbursed up to a maximum of \$100 at each draw.

Newfoundland Pharmaceutical Association

- The Association provides no funding to individuals for continuing education/professional development.
- There is an Education Committee that organizes and coordinates or sponsors continuing education programming. The expenditure in this area last year was \$2000.
- Most of the continuing education programs are funded by educational grants from drug manufacturers, while some programs are paid for directly by participating pharmacists.

Council for Licensed Practical Nurses

- The only educational funding is an Excellence in Practice Award, which awarded each year to one LPN. The award consists of \$500 towards continuing education.

Newfoundland and Labrador Association of Occupational Therapists

- Continuing education and professional development opportunities in the last fiscal year:
 - AGM Education Draw of \$500 – members attending the AGM have their names entered into the draw. The funding is to be used for an educational event within the upcoming fiscal year.
 - Dalhousie University Book Draw of \$50 – provided to the School of OT in September each year.
 - Canadian Association of Occupational Therapists (CAOT) conference sponsorship of \$1000 – awarded to a member who attends the annual national conference. Members who are planning to attend submit their name, and a draw takes place at a general meeting of the membership. The amount is used towards registration and/or travel costs.
 - CAOT Tel-Ed workshop was funded in the last fiscal year.
 - A travel grant of \$1000 was distributed among 6 members traveling from outside St. John's, to attend a workshop that took place.
 - \$500 is allocated to the Canadian Occupational Therapy Foundation (COTF) fund in the budget, however the award has not been distributed to date.

- In the current fiscal year:
 - NLAOT was able to offer two \$800 grants to members who were traveling to the OT Atlantic Conference as presenters. Support for members to present at OT Atlantic, when it is outside the province, is planned to be repeated each year.
 - The CAOT Conference draw will be repeated.
- The NLAOT Education Committee is primarily active in organizing workshops within the province and is also responsible for setting the fees for the workshops.

Unions

Newfoundland and Labrador Nurses' Union

- NLNU offers \$11,000 annually in scholarships.
- These scholarships are for the post-basic BN degree, Masters, postgraduate programs, and nursing certificate programs.
- Information and criteria about receiving the scholarships can be found on the NLNU web-site (available at www.nlnu.nf.ca/membership).

Association of Allied Health Professionals (AAHP)

- AAHP has an Education Fund, which awards a total of \$10,500 yearly. There are three draws of \$3500 each.
- There is an Education Fund Committee, which consists of three AAHP members at large, the President and the Administrative Director.
- The maximum amount of funding a member can receive in any 12 month period is \$500.
- Money is allocated using a lottery draw system.
- Only members of the AAHP are eligible to apply.
- The Education Fund Guidelines and Application can be found on the AAHP web-site (available at www.aahp.nf.ca/edlines).

Other

Newfoundland and Labrador Health Boards Association

- Have the Education Support Fund of \$118,000 per year.
- Member organizations submit proposals for funding from the Education Support Fund, which must meet outlined criteria.

12 Appendix C: Newfoundland and Labrador Health Knowledge Information Network

December 7, 2001

Leslie Harnett
Newfoundland & Labrador Health Boards Association
P.O. Box 8234 Stn "A"
St. John's, NF
A1B 3N4

Dear Leslie;

Enclosed as you requested is an estimate of the cost required to expand the Newfoundland & Labrador Health Knowledge Information Network (NLHKIN) to service all of the regional health boards within the province. This includes both the institutional and community services boards. The NLHKIN currently has eight corporate members and over two hundred individual health professionals registered for access through their health organization's membership.

The NLHKIN has demonstrated its usefulness to health professionals, particularly those in rural and under-serviced areas outside of St. John's. In addition to its usefulness for health professionals, the NLHKIN has also proven to be an effective tool for sharing costs for costs for expensive information services and resources. Some member organizations have been able to reduce their costs for accessing information resources by using the shared NLHKIN resources. We have been successful in providing access to a particularly valuable resource, MD Consult, through a co-operative arrangement with other health libraries in Atlantic Canada through the Atlantic Health Information Partnership.

To service all of the health boards NLHKIN needs to increase its licenses for numbers of users of existing licensed resources; add more information resources in the form of electronic journals accessible through the Internet; and add a dedicated librarian to lead the project.

I have added a budget line for electronic journals since this is the most obvious weakness in the current NLHKIN and the one for which we get the most requests. Unfortunately, health sciences journals are normally NOT free on the Internet but it is possible to negotiate consortium packages that will provide effective access to the health sciences literature.

The development of the current NLHKIN has been significantly delayed by the lack of dedicated staff that can promote the network, develop and provide training opportunities for members, and actively seek out additional relevant information resources and services. Moving to service all of the provincial health boards would make it imperative that some dedicated staff be allocated to the network.

The Health Sciences Library is willing to provide an administrative "home" and support services for NLHKIN. In the proposed budget some \$60,000 of the costs are currently covered by the existing NLHKIN membership. The major additional costs would be for increasing the MD Consult simultaneous user license, adding a selected collection of electronic journals, and upgrading the NLHKIN support infrastructure through the addition of a dedicated staff member and some hardware upgrading. There is some flexibility in designing the range of services and resources to be provided. My sense is that the absolute minimum for a useful service would be the CINAHL database; MD Consult, funding for an e-journal package, and the infrastructure support.

I would be pleased to talk more with you about the NLHKIN and the possibility of increasing its services to health professionals throughout the province at your convenience.

Yours sincerely,

George Beckett
Associate University Librarian (Health Sciences)

**Newfoundland & Labrador Health Knowledge Information Network
Proposed Budget to Service All Provincial Health Boards
Revised: December 7, 2001**

All costs are annual and in Canadian dollars

Information Resource Licensing

MEDLINE	\$15,850
CINAHL ¹	\$12,600
Harrision's Online	\$ 1,800
STAT!REF ²	\$ 8,500
MD Consult ³ 5 users @ \$3,500/user	\$17,500
New - Consortium licensing for access ⁴ to electronic journals – estimated	\$40,000

Sub-Total **\$96,250**

Notes

¹Cumulative Index to Nursing & Allied Health Literature

²STAT!REF provides full-text access to over 30 clinical textbooks and drug reference guides (no overlap with MD Consult)

³MD Consult provides full-text access to 45+ clinical journals, 35+ core medical textbooks, 600+ peer reviewed clinical practice guidelines, drug information for more than 30,000 medications and about 3000 customizable patient education handouts

⁴This is an estimate of the cost to acquire access to a reasonable package of health journals in addition to those in the MD Consult service

NLHKIN Infrastructure

1 full time librarian@ \$40,000 + 15% benefits	\$41,400
Travel & promotion funding	\$ 8,000
Remote access gateway server upgrade	\$ 2,000
Database server upgrade	<u>\$ 2,500</u>

Sub-Total **\$53,900**

Total Annual Costs **\$150,150**

13 Appendix D: Summary of Information and Research Programs

Newfoundland & Labrador Health Knowledge Information Network

George Beckett at the Health Sciences Library of MUN developed a proposal for a Newfoundland & Labrador Health Knowledge Network (NLHKN), now known as Newfoundland & Labrador Health Knowledge Information Network (NLHKIN) and presented it to the Newfoundland & Labrador Centre for Health Information (NLCHI) in 1998. The proposal was presented to NLCHI in hopes that the Centre would be able to support and sponsor the project, and help obtain funding from government to initiate the project. While NLCHI did provide some sponsorship, the proposal was not successful at that time in obtaining funding from government.

The NLHKIN is designed to provide timely access to health information for health professionals throughout the province. The model is to provide Internet-based access to health professionals throughout the province using the shared funding of members to fund the resources (Beckett, G., personal communication, October 23, 2001). NLHKIN would provide its members with unlimited access to selected health periodical index databases combined with electronic ordering of requested resources and electronic delivery of information to central locations in each region of the province (Beckett, 1998).

The Health Sciences Library decided to implement a scaled-down version of NLHKIN as a pilot project in 2000. A survey of members in Fall of 2000 resulted in a decision to continue with the project in 2001. To date, most of the institutional health boards are members (Beckett, G., personal communication, October 23, 2001).

Health Canada – Office of Health and the Information Highway

The Office of Health and the Information Highway (OHIH) sponsors a web-site as an information resource on information and communications technologies (ICTs) in health as well as a means of sharing information about the work of the Office. More information is available at <http://www.hc-sc.gc.ca/ohih-bsi/>

Newfoundland and Labrador Centre for Applied Health Research

The Centre for Applied Health Research (CAHR) was established in September, 1999 as a partnership between MUN, the Department of Health and Community Services, and the Health Care Corporation of St. John's. Its mandate is to increase the province's capacity to carry out high quality research on applied health issues (Available at www.med.mun.ca/cahr). One of the ways the Centre intends to fulfill its mandate is through a Research Grant program. These grants are intended to support research on applied health issues in a variety of areas. The following table is a list of grants available for the 2001-2002 year.

Grants	Maximum Amount of Grant	Duration	Prerequisites	Grants Available	Application Deadline
Project	\$40,000	1 year	Full-time researchers from an academic, health or community service institution in the province.	1 or more	January 15, 2002
Development	\$10,000	1 year	Full-time researchers from an academic, health or community service institution in the province.	6	January 15, 2002
CHSRF Partnership	\$30,000/yr	3 years	Researchers based in the province applying as a PI to the CHSRF Open Grants Program.	1 or more	LOI: November 7, 201 Full App: March 20, 2002
Visiting Lecturer Awards	\$1,000	--	Lecturers' visit should be of significant benefit to the hosts and contribute to the health research community.	5	Open

Project - Intended to support small projects of high quality that may not be eligible for funding from external sources and are of direct relevance to the mandate and priorities of the CAHR.

Development - Purpose is to support the development of effective research teams able to obtain research funding from national and/or international research funding agencies to further applied health research in this province.

CHSRF Partnership - Provide matching funding to support or enhance research projects.

Visiting Lecturer Awards - To assist academic units who would like to invite applied health research specialists to the province.

More information on the CAHR is available at www.med.mun.ca/cahr.

14 Appendix E: Audit of Provincial Seat Purchase and Bursary Programs

Physiotherapy

- 79 students have graduated from PT at Dalhousie University in the seat-purchase program since 1994.
 - 56% have fulfilled or are fulfilling return-in-service (RIS) commitments.
 - 29% of students have repaid or are in the process of repaying.
 - 10% have either been released from the contract, referred for collection, or written off.
 - We are unsure of 5% of the graduates, i.e. if they returned to the province, if they fully completed and/or repaid RIS commitments, etc.
- A total of 206.75 person years were owed in RIS from 1994 – 2001.
 - 70% of these person years are fulfilled through returning service or repayment.
 - Approximately 24% of the remaining person years are in the process of being fulfilled, i.e. graduates from 1999, 2000, and 2001 are still fulfilling RIS commitments.
 - About 6% of the total person years have been referred for collection, or we have no information at this time.
- There have been 43.05 person years of service beyond commitment from 79 PTs who graduated between 1994 and 2001 (~ 0.54 years beyond commitment for each graduate).
- Currently:
 - 35 (44%) are employed in the provincial public sector.
 - 8 (10%) unknown location/employment.
 - 25 (32%) are out-of-province.
 - 11 (14%) are employed in the provincial private sector.

Occupational Therapy

- 68 students have graduated from OT at Dalhousie University in the seat-purchase program since 1994.
 - 66% have fulfilled or are fulfilling return-in-service (RIS) commitments.
 - 19% of students have repaid or are in the process of repaying.
 - 7% have either been released from the contract, referred for collection, written off, or other.
 - We are unsure of 6% of the graduates, i.e. if they returned to the province, if they fully completed and/or repaid RIS commitments, etc.
- A total of 175.25 person years were owed in RIS from 1994 – 2001.
 - 67% of these person years are fulfilled through returning service or repayment.
 - Approximately 29% of the remaining person years are in the process of being fulfilled, i.e. graduates from 1999, 2000, and 2001 are still fulfilling RIS commitments.
 - About 4% of the total person years have been referred for collection, written off, other, or we have no information at this time.
- There have been 67.2 person years of service beyond commitment from the 68 OTs who graduated between 1994 and 2001 (~ 1.0 year beyond commitment for each graduate).
- Currently:
 - 39 (57%) are employed in the provincial public sector.
 - 8 (12%) unknown location/employment.
 - 11 (16%) are out-of-province.
 - 7 (10%) are employed in the provincial private sector.
 - 3 (4%) other.

Bachelor of Nursing

In 2000 and 2001, BN graduates were eligible to received a \$3000 bursary from the Department of Health & Community Services, in return for a 1-year RIS to the province. The following is an evaluation of the bursary program to date.

2000 BN Graduates

- 148 of 163 (91%) graduates accepted the bursary.
- 120 (81%) of those that accepted the bursary completed the 1-year RIS.
- 109 (74%) of those who accepted the bursary continued to work in the provincial health boards following completion of the RIS.
- 20 (14%) of the 148 are out of the province at the time of this paper.
- For 19 (13%) of the 148 BN graduates who accepted the bursary, their location is unknown.

2001 BN Graduates

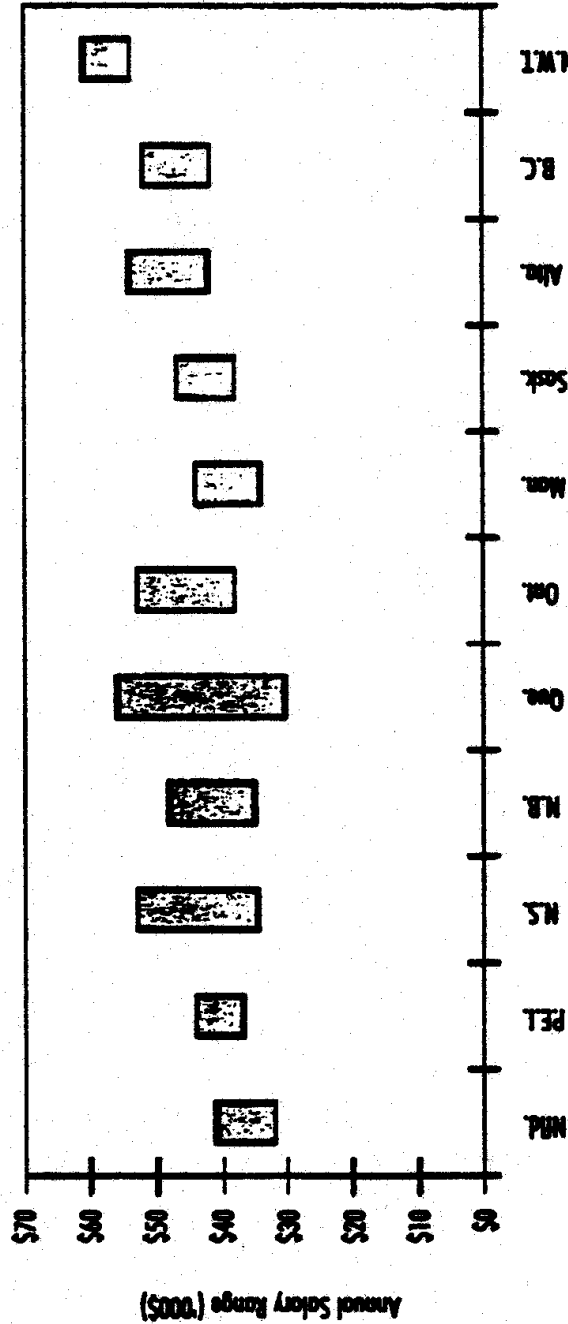
- 153 of 162 (94%) graduates accepted the bursary.
- At the time of this paper, 2 of the 153 (1%) had left the province and would be repaying the bursary.

15 Appendix F: Salary Scales

**Obtained from Canadian Institute for Health Information. (2001). Canada's health care providers. Ottawa, ON: Author.

Physiotherapy/Occupational Therapy Salaries Compared

Salaries of clinical physiotherapists and occupational therapists vary from coast to coast. The graph below shows minimum to maximum annual salary range for therapists practicing full-time in the public sector by province and for the Northwest Territories in 2000.



Source: Francis & Associates, Personnel Placement for Canadian Health Professionals Survey, 2000. As presented in Physiotherapy in Manitoba, Canadian Physiotherapy Association, Manitoba Branch, 2001.

How Much General Duty RNs Earn

Many of Canada's nurses work on hospital wards and in other settings under contracts negotiated by their unions. Minimum and maximum salaries (excluding overtime) for general duty registered nurses compiled by the Canadian Federation of Nurses Unions for the year 2001 are show below. The date that the latest increase became effective is also listed.

UNION NAME	Annual Income		Latest Increase Effective
	Minimum	Maximum	
Newfoundland/Labrador Nurses' Union	\$37,716	\$46,953	1/5/01
Prince Edward Island Nurses' Union	\$37,733	\$45,981	1/4/01
Nova Scotia Nurses' Union	\$43,572	\$51,123	1/11/01
New Brunswick Nurses' Union	\$38,727	\$47,132	1/7/01
Federation des infirmieres et infirmiers du Quebec	\$32,252	\$48,049	1/1/01
Ontario Nurses' Union	\$39,975	\$58,968	1/4/00
Manitoba Nurses' Union	\$41,225	\$48,600	1/4/01
Saskatchewan Union of Nurses	\$39,970	\$48,564	1/4/01
United Nurses of Alberta	\$43,297	\$52,275	1/4/01
British Columbia Nurses' Union	\$43,123	\$55,900	1/10/01

Note: Figures have not been adjusted for other differences in working conditions or the cost of living.

¹There are two wage increases in 2001: 0.5% January 1, 2001 and 1% July 1, 2001.

²No wage increases for 2001; therefore the wages remain at the 2000 level for this table. The Ontario Nurses' Association contract expired 31/03/01.

³Two wage increases in 2001. The new UNA contract expires 31/03/03.

Source: Canadian Federation of Nurses Unions

16 Appendix G: Summary of Proceedings and Recommendations of the Provincial Physician Recruitment and Retention Coordinating Committee

REPORT TO THE MINISTER OF HEALTH

Summary of Proceedings and Recommendations of the Provincial Physician Recruitment and Retention Coordinating Committee

February 9, 1999

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SECTION 1

*Report to the Minister of Health and Community Services
Summary of Proceedings and Recommendations
of the
Provincial Physician Recruitment and Retention
Coordinating Committee*

(February 9, 1999)

Report to the Minister of Health and Community Services

Summary of Proceedings and Recommendations of the Provincial Physician Recruitment and Retention Coordinating Committee (February 9, 1999)

The **Provincial Physician Recruitment and Retention Coordinating Committee** was initiated in July 1998 to advise the Minister on this important issue (see Terms of Reference, Section 5). The Committee identified several areas of importance in successfully addressing physician recruitment and retention in the province and focused primarily on recruitment processes in the province and effective incentive management strategies. The detailed subgroup reports are attached.

There was unanimous agreement that one issue can not be isolated from others. Issues and solutions are very interwoven and include: good communication activities between Boards, physicians, and medical students/residents; quality of life issues in the communities; employment issues of significant others; incentives; and salary. All have a direct impact on success. Other issues were also identified, such as mentoring of students by faculty at MUN and marketing strategies.

Recommendations

The **Provincial Physician Recruitment and Retention Coordinating Committee** submits the following recommendations to the Minister of Health and Community Services for consideration, based on the recommendations of the two subgroups:

1. An Advisory Committee should be established to oversee physician recruitment and retention activities provincially. This committee would also advise on policy direction, administer incentive programs and specific training initiatives, and evaluate and monitor trends.
2. Greater collaboration between stakeholders is needed, with improved linkages between Regional Boards and fee-for-service physicians. Some expansion of the current NLHCSA recruiter's role is suggested to assist fee-for-service physicians.
3. Priority for recruiting should be focused on (a) Newfoundland and other Canadian residents in Memorial Medical School and NF students or graduates abroad, (b) Canadian graduates in general, and (c) International graduates. Investment in students and residents at Memorial must be a long-term process over their years of training.
4. A "Career Office" concept should be considered at MUN Medical School that facilitates access of Board and fee-for-service physicians to MUN Medical School students and residents, provides career information, and participates in recruitment

efforts. The NLHCSA recruiter should also increase visibility at MUN Medical School.

5. All incentive programs and specific training initiatives should be linked to Physician Human Resources Plan. Based on this plan, pooling of incentive funding should be considered (Resident and Medical Student Practice Incentive, the Medical Speciality Bursary, and the Psychiatry Bursary) to assure areas of greatest need are given priority.
6. The model of incentive funding attached is recommended that ensures stability over the next several years and provides students with predictable incentive programs.
7. Additional funding should be invested in the incentive program to address the gap between the Family Practice Resident incentives, the Psychiatric and Medical Resident Bursary Programs in future years. There was a recommendation by PARIN that all financial incentives at the resident level be equal.
8. A model of medical student incentive that provides greater flexibility by separating a tuition component from an incentive component is suggested. Any change in tuition should be indexed and tied to this allocation.
9. That monies recouped from students who do not complete their return-in –service be reinvested in the appropriate incentive or bursary program and that the Resident and Medical Student Practice Incentive Program funding be maintained separate from other recruitment incentives. Funds should not be reallocated for other recruitment strategies, e.g., housing, CME, travel, site visits, signing bonuses, etc.

These recommendations are addressed in greater detail in the attached sup-committee reports.

Conclusion

The Committee concluded that physician recruitment and retention in Newfoundland and Labrador will continue to be a challenging area of priority for the Province. Collaboration, focused attention, proactive strategies, and monitoring of this issue are needed.

17 Appendix H: Summary of current provincial government-funded bursary programs

Health Boards and the Government of Newfoundland and Labrador, in order to attract health professionals and retain graduates from health professional programs in the province have offered recruitment bonuses and bursary programs. The following is a breakdown of bursaries and incentives offered by the Government of Newfoundland and Labrador in fiscal year 2001-2002. More details are available at www.gov.nf.ca/health.

Resident and Medical Student Practice Incentive Program	\$575,100.00
Medical Specialist Resident Bursary Program	87,500.00
Psychiatric Resident Bursary Program	72,500.00
Traveling Fellowship Program	300,000.00
Radiation Therapy Seat Purchase Program	0.00*
Allied Health Seat Purchase and Bursary Program	500,000.00
Rural Nursing Student Incentive Program	75,000.00
Nurse Practitioner Bursary Program	75,000.00
Nursing Graduate Bursary	Currently not available

A audit of those who have gone through the Dalhousie Occupational Therapy and Physiotherapy programs on seat purchase and/or who have received bursaries from 1994 – 2001 can be found in Appendix E.

* Note there are current students under sponsorship at Mitchener Institute whose funding is coming from unused funds from other bursary programs.