Report of the Independent Expert Panel on Executive Compensation in the Hospital Sector

Independent Expert Panel
The Honourable John Manley, P.C., O.C. (Chair)
William Anderson
Peter Barnes

November 11, 2011

Board of Directors
Ontario Hospital Association

We are pleased to submit our *Report of the Independent Expert Panel on Executive Compensation in the Hospital Sector*. We hope that you find our deliberations and recommendations useful.

Yours truly,

John Manley William Anderson Peter Barnes
Chair

CONTENTS

Part A: Background

1. Creation and Role of the Independent Expert Panel

Executive compensation in Ontario's 151 hospital corporations has come under increasing scrutiny in recent years. Media representatives, members of the public and elected officials have raised questions about pay levels, the various components of executive compensation, performance expectations, and accountabilities for the use of public funds. The Ontario Government has developed policies and enacted legislation to establish parameters for compensation in the public sector, and in hospitals in particular. As of January 1, 2012, hospitals in Ontario will be covered by freedom of information legislation for the first time, which means that members of the public will be able to request access to a wide range of hospital records, including executive contracts.

In the summer of 2011, the Board of Directors of the Ontario Hospital Association (OHA) agreed on the need for a thorough and thoughtful review of hospital executive compensation, the findings of which would enable the OHA to provide improved guidance to hospital boards on executive compensation. To ensure that this review was comprehensive, well-informed, arm's-length and objective, in July 2011 the OHA Board created an Independent Expert Panel on Executive Compensation in the Hospital Sector.

The OHA Board's Executive Committee approached three prominent and respected individuals, each of whom agreed to serve on the Independent Expert Panel:

- The Panel Chair, the Honourable John Manley, P.C., O.C., is President and Chief Executive Officer (CEO) of the Canadian Council of Chief Executives. In addition to his private sector experience, he has served as Deputy Prime Minister of Canada and federal Minister in the portfolios of Industry, Foreign Affairs and Finance.

- William Anderson, FCA, is currently Chair of Nordion Inc. and a Director of TransAlta Corporation, Gildan Activewear Inc. and Sunlife Financial Inc. Mr. Anderson is a former Chief Financial Officer of BCE/Bell Canada. He is a Fellow of the Institute of Corporate Directors.

- Peter Barnes served the Ontario Government as Secretary of Cabinet, Clerk of the Executive Council, Deputy Minister of Economic Development and Trade, and Deputy Minister of Community and Social Services.

The Panel's mandate was to provide recommendations to the OHA Board on appropriate executive compensation policy, sustainable over the long-term, and practice guidelines for the range of hospitals in Ontario. The Panel was also asked to assess the potential impact that recent government initiatives could have on the recruitment and retention of Ontario hospital executives. (See Appendix A for the Panel's terms of reference.)

The Panel members agreed to conduct their review subject to the following working principles:

- The Panel is independent and arm's-length from the OHA and its members. The Panel is not an agent of the OHA and the Panelists themselves are independent of all hospitals. OHA staff were available to the Panel to provide information only.[1]
- The Panel was assisted by a consulting firm with expertise in executive compensation. The firm, Mercer (Canada) Limited, was selected through a competitive bidding process. The Panel directed the work of the consulting firm, which provided its research findings and advice directly to the Panel for its sole use and to inform its deliberations.
- The Panel developed its report independently of both the OHA and the consulting firm, using the services of an independent writer.
- The OHA agreed to publish the Panel's final report within 60 days of its submission to the OHA Board.
- Panel members took on the task voluntarily and were not compensated for their time.

The Panel initially intended to address compensation for a wide range of senior hospital executive positions, including President and CEO, Chief Operating Officer, Chief Financial Officer, Chief Human Resources Officer, Vice-President Research and Vice-President Patient Care and Chiefs of Staff. In the end, the Panel decided to focus on developing a solid CEO compensation framework that establishes a reference point for other hospital executive positions.

The Panel's deliberations were based on Ontario's current system of hospital governance. The Panel's mandate did not include assessing whether Ontario's model of hospital governance is appropriate.

2. Ontario Hospitals

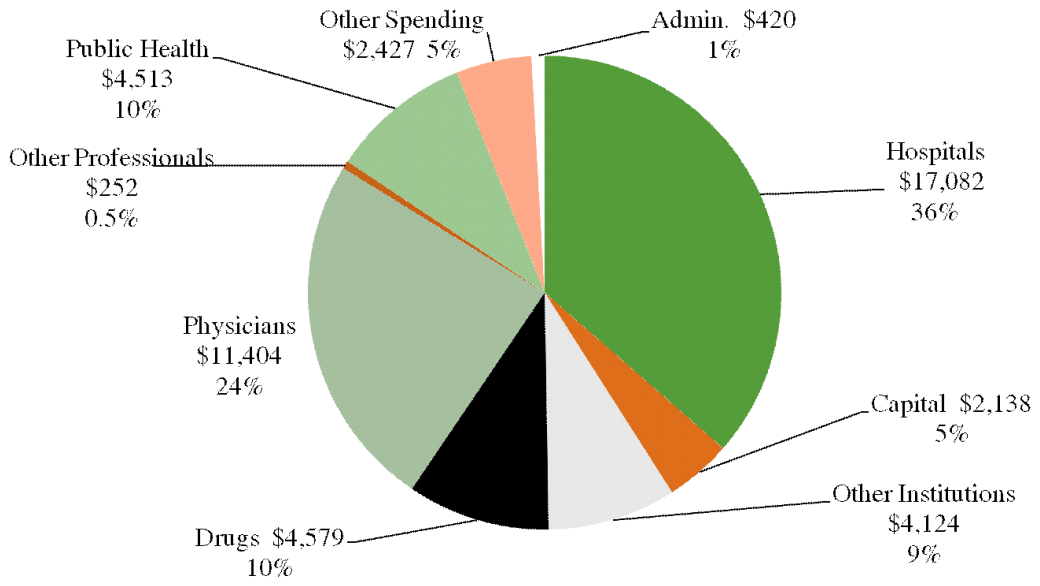
Ontario has 151 public hospital corporations which operate on 234 sites. Key points:

- Hospitals operate in a wide range of environments, from small rural communities to large cities.
- Hospitals vary in size and complexity. For example, Hornepayne Community Hospital in rural Northern Ontario has total revenues of $5 million and provides emergency, acute and long-term care services to its local community on one site. In contrast, University Health Network (UHN) in Toronto has total revenues of $1.75 billion, including about $283 million in research funding. UHN encompasses nine sites that provide emergency, acute, rehabilitation, complex continuing and long-term care to a population extending well beyond the Greater Toronto Area. Some of UHN's highly specialized programs serve patients across Ontario (e.g., organ transplants and treatment for rare cancers). UHN is one of 25 academic health science centres in Ontario that play an vital role in educating medical and other healthcare students, and conducting world-leading research.

[1] Two OHA staff regularly attended the open portion of the Panel's meetings: Tom Closson, President and CEO, and Julie Giraldi, Chief Human Resources Officer and Vice President Health Human Resource Leadership. These staff did not attend the *in camera* portions of the Panel's meetings.

- Many hospitals and hospital CEOs work with hospital foundations, which are independent corporations created to raise additional funds for the hospital. Larger hospitals that were created by amalgamating a number of hospitals tend to have multiple foundations.
- Hospitals receive $17.1 billion in provincial funding, equal to 36% of the Ontario Government's healthcare budget (Figure 1).
- This accounts for about 74% of total Ontario hospital revenues. The remaining 26% is generated from other sources including foundations and research grants, as well as services such as parking, the provision of semi-private and private accommodation, retail operations (e.g., cafeteria, stores) and Worker's Compensation payments.
- Total Ontario hospital revenues were $23 billion in 2010.
- The Ontario Ministry of Health and Long-Term Care provides capital funding separately for major construction and redevelopment projects.

Figure 1: Ontario Provincial Government Health Expenditures by Category, in $ Millions, 2010 (Total Expenditures: $46,939 Million)



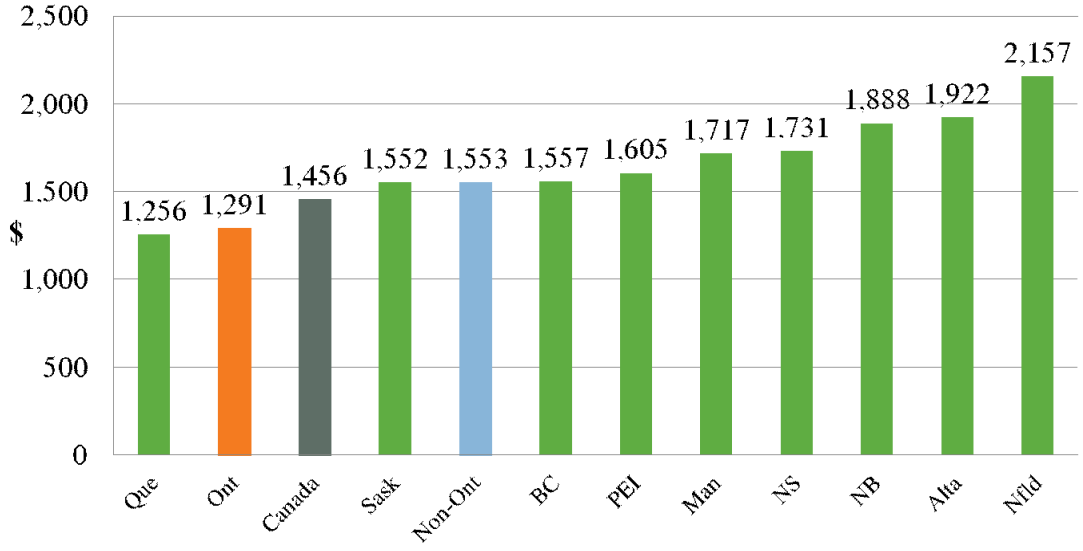
Source: National Health Expenditure Database, Canadian Institute for Health Information, 2010. Notes: Data for 2010 are forecast. Other professionals: dental, vision and other. Drugs: prescribed and non-prescribed incl. med supplies. Other spending: health research, home care, medical transportation, hearing aids, other appliances, training of health workers and voluntary health associations. Long Term Care homes are in Other Institutions.

- The Ministry funds hospitals primarily using a global or base-funding approach. Some hospitals also receive special program funding to provide Ministry-approved new or expanded programs and specialized services (dialysis, cardiovascular treatments, additional procedures to reduce wait times, etc.). The size of a hospital's budget depends on the size and complexity of the organization and the services it provides.

Compared to their counterparts in other provinces, Ontario's hospitals appear to perform well in terms of efficiency and effectiveness:

- In 2010, Ontario's total hospital expenditures were $1,291 per capita, the second lowest in Canada (Figure 2).
- The total number of beds staffed and in operation in Ontario hospitals decreased 38% between 1990 and 2011. The total number of acute-care beds decreased 46%.[2] During the same period, Ontario's population increased 30%, to 13.4 million.
- Ontario's acute inpatient hospitalization rate per 100,000 population is the lowest in Canada when standardized by age (Figure 3).
- Ontario's hospitals have the second-lowest acute inpatient average length of stay, at 6.9 days (Figure 4).

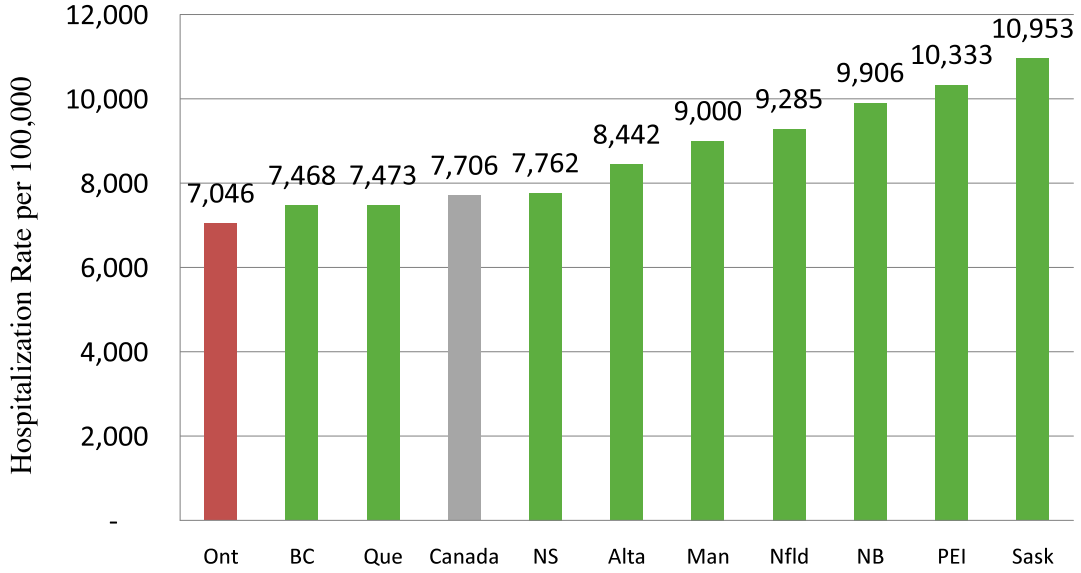
Figure 2: Government Hospital Expenditures per Capita, 2010



Note: Data for 2010 are forecast. Canada average includes the territories. Non-Ont: NL, PEI, NS, NB, Que, Man, Sask, Alta, B.C.
Source: National Health Expenditure Database, Canadian Institute for Health Information, 2010.

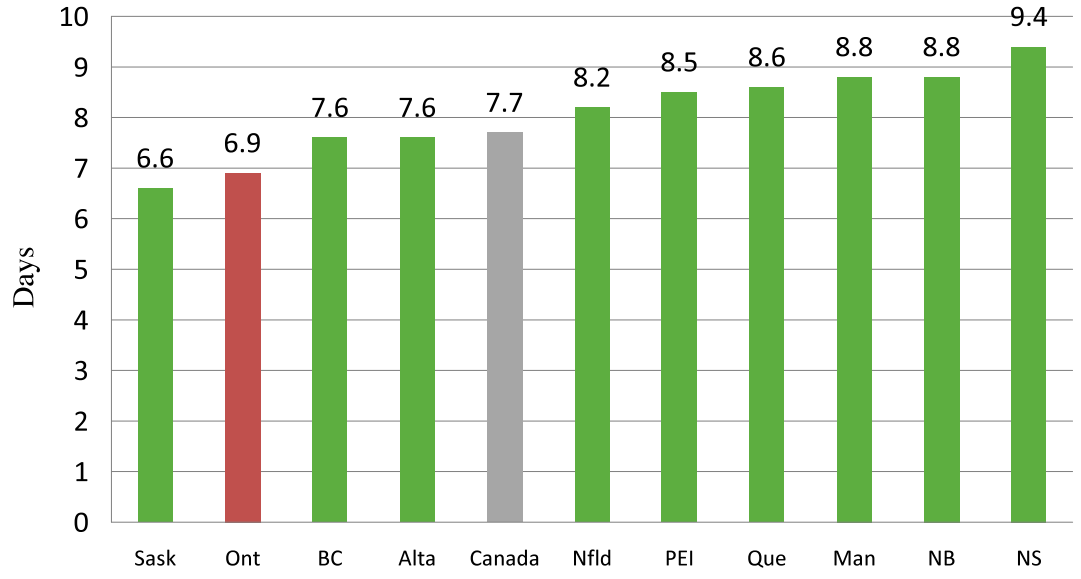
[2] Source: Hospital Statistics, 1989/90 to 1992/93. Daily Census Summary, Ministry of Health and Long-Term Care, 1993/94 to 2010/11.

Figure 3: Age-Standardized Acute Inpatient Hospitalization Rate per 100,000 Population, 2009/10



Source: Canadian Institute for Health Information. Highlights of 2009-2010 Inpatient Hospitalizations and Emergency Department Visits, May 2011.

Figure 4: Acute Inpatient Average Length of Stay, 2009/10



Source: Canadian Institute for Health Information. Highlights of 2009-2010 Inpatient Hospitalizations and Emergency Department Visits, May 2011.

- Ontario hospitals rank highly on standard national wait time measures for hospital-based procedures.[3] In 2010, for example, Ontario and British Columbia were the only provinces in Canada in which hospitals completed at least 75% of hip and knee replacements, hip fracture repairs, cataract surgeries, cardiac bypass surgeries and radiation treatments within benchmark wait times.
- For all of the above procedures except hip fracture repairs, Ontario's wait times were shorter than those of British Columbia. Ontario's wait times were equal to or shorter than the wait times for most of the six procedures in all the other provinces.

3. Hospital Executive Compensation in Ontario

Public hospitals in Ontario are governed by voluntary local boards of directors, the members of which possess a wide range of skills, expertise and community knowledge. Ontario is the only province in Canada in which every hospital has its own local board. Over the past two decades, all other provinces have replaced most of their local hospital boards with regional health authorities. Although Ontario introduced 14 Local Health Integration Networks (LHINs) in 2006 to oversee planning, integrating and funding services in their local areas, the provincial government kept intact the voluntary local hospital board structure.

Each hospital board determines the compensation and conditions of pay of its President and CEO.[4] In most cases, the CEO is responsible for setting the compensation and conditions of pay for other members of the executive team.

A hospital board's decisions about executive compensation are generally based on, or informed by:

- The personal experience and expertise of board members and their knowledge of best practices;
- The OHA's annual executive salary survey and its guidelines for hospital executive compensation;[5]
- Ontario's Public Sector Salary Disclosure database, which reports compensation for public sector employees who are paid $100,000 or more in a year; [6] and
- Custom market surveys and/or compensation consultants, engaged primarily by larger hospitals.

[3] Canadian Institute for Health Information. 2011. Wait Times in Canada: A Comparison by Province.
[4] For ease of reading, the term "CEO" will be used to refer to "President and CEO."
[5] Ontario Hospital Association, Governance Centre of Excellence. 2006 (February). Guidelines and Principles for Hospital Executive Compensation (Publication #411). Prepared for Use of OHA Member Hospital Boards and CEOs by HayGroup.
[6] The list is publicly available at http://www.fin.gov.on.ca/en/publications/salarydisclosure/2011/.

A number of other factors influence hospital executive compensation in Ontario:

Location and Characteristics of the Hospital

CEOs of smaller hospitals with smaller budgets and fewer services are generally paid less than CEOs of larger hospitals. The board of a larger hospital may approve a higher compensation level for a CEO who: manages a complex range of programs; works with multiple communities; manages clinical, research and education activities; partners with one or more hospital foundations; and/or plays a regional, provincial or global role. The board of a smaller hospital – particularly one located in a rural or remote area of the province – may increase the level of CEO compensation in order to attract a qualified candidate to the community.

When setting executive compensation levels, the boards of smaller hospitals may also need to consider the issue of salary compression (defined as a reduction in salary differentials between employees at different levels of the organization).

Market Competition

Hospitals compete with a wide range of employers in both the public and private sector to recruit and retain executives. For some positions, such as Vice President Human Resources or Vice President Finance, the market is fairly broad since the skills of those professionals are transferable across sectors. In contrast, CEOs and top clinical staff (such as Vice-President Patient Care or Chief Nursing Executive) tend to be recruited from within the hospital sector. If a hospital is situated in a highly competitive market with other potential employers nearby, the hospital board may need to increase the compensation level to attract qualified candidates. Similarly, a board might decide to increase pay rates if it has experienced problems recruiting or retaining executives.

Personal Qualifications and Competencies of the Executive

A hospital board may offer a higher level of compensation to a CEO with advanced management training or experience. If the CEO candidate is a physician, the board in most circumstances will take into account what he or she could earn in clinical practice.

External Requirements from Legislation and Government Policy

In recent years, the Ontario Government has introduced a number of measures that directly or indirectly impact hospital executive compensation rates:

Bill 16: Creating the Foundation for Jobs and Growth Act, 2010 (Public Sector Compensation Restraint to Protect Public Services Act 2010)

On May 18, 2010, the Ontario Government passed *Bill 16*, omnibus legislation to support various initiatives in its 2010 budget.[7] *Bill 16* imposed a two-year freeze on compensation for non-bargaining employees in the Ontario Public Service and the broader public sector. Unionized employees are exempt from the legislation. The Act prohibits pay increases beyond the levels that existed on the effective date of the legislation (March 24, 2010), and also prohibits increases in any existing benefits, perquisites or payments under a compensation plan. Compensation includes base pay, merit pay, time off such as vacation, pension, health and other benefits. The Act contains a provision banning any immediate "catch up" in salary once the bill expires.

Bill 46: The Excellent Care for All Act, 2010

On June 8, 2010, the Ontario Government passed *Bill 46,* which imposed increased accountability on hospital boards for quality, safety and the overall patient experience. The Act requires hospitals to develop annual Quality Improvement Plans (QIPs) and make them available to the public. In addition, as of April 1, 2011, the Act required hospitals to link a portion of executive compensation to the achievement of targets set out in the QIP.[8] The Act and its regulations did not define the percentage of compensation that must be tied to performance. Where there is conflict between the Act and an existing compensation plan, the Act prevails.

Bill 122: The Broader Public Service Accountability Act (BPSAA), 2010

On December 8, 2010, the Ontario Government passed *Bill 122,* which will make hospitals subject to Ontario's *Freedom of Information and Protection of Privacy Act*. As of January 1, 2012, any individual will be able to request information on hospital executive compensation, including supporting employment contracts, dating back five years. Details about physician compensation, appointments and privileges are not required to be disclosed.

Bill 173: Better Tomorrow for Ontario Act (Budget Measures), 2011

On May 12, 2011, the Ontario Government passed *Bill 173* in support of its 2011 budget. This omnibus legislation, which amended *Bill 122*, enabled the Management Board of Cabinet to issue directives requiring designated public sector organizations to establish rules about perquisites. On August 2, 2011, Management Board issued the Broader Public Sector Perquisites Directive, which requires designated organizations, including

[7] Ontario Government. 2011. *Turning the Corner to a Better Tomorrow: 2011 Ontario Budget*. Toronto: Queen's Printer.

[8] An executive is defined as the CEO (or equivalent), members of senior management reporting directly to the CEO or equivalent, the Chief of Staff (where this exists), and the Chief Nursing Executive. Compensation is defined as any form of payment, benefits and perquisites paid or provided, including discretionary payments.

hospitals, to establish rules about perquisites covering all individuals in the organization. A perquisite is a privilege that is provided to an individual or to a group of individuals, provides a personal benefit, and is not generally available to others. To be allowable, a perquisite must be a business-related requirement for the effective performance of an individual's job. The Directive also identified perquisites that are not allowed under any circumstance.

2011 Ontario Budget: Executive Office Expenses

In its 2011 budget, the Ontario Government stated its intention to reduce, by 10% over two years, funding for executive offices of hospitals, school boards, universities and other specified recipients of provincial transfer payments. To date there have been no legislative provisions to support this action.

4. Components of Total Compensation

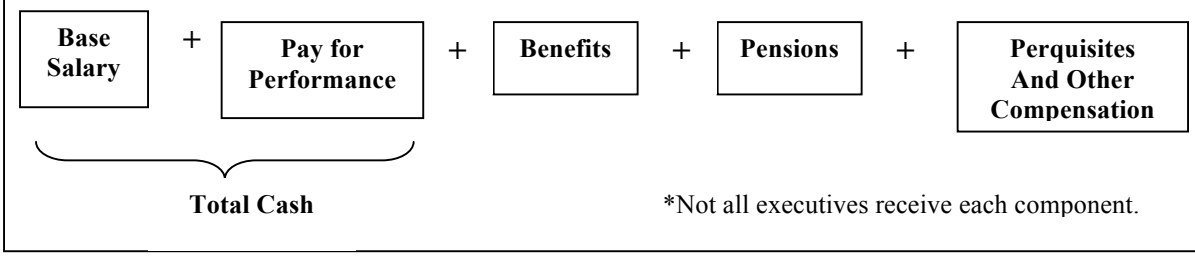
Total compensation for executives in Ontario's hospitals can include five components (Figure 5):

Base Salary is generally reviewed annually and paid to employees in regular instalments throughout the year.

Pay for Performance links pay to the achievement of annual performance goals and targets. As noted above, Ontario hospitals have been required since April 1, 2011, to adopt performance-based compensation plans for their executives.

Benefits are payments or non-cash entitlements that are of value or use to the employee. They can include supplementary healthcare, group life insurance, long-term disability, etc. Benefits tend to be universal rather than performance-based.

Figure 5: Components of Total Compensation *



Pensions are a form of supplementary retirement income that is earned by the employee over the course of his or her employment. A variety of pension arrangements cover hospital executives:

- Most hospitals in Ontario (and their executives and employees) participate in the Healthcare of Ontario Pension Plan (HOOPP), a defined benefit plan that provides eligible members with a retirement income based on a formula that takes into account a member's earnings history and length of service in the plan.
- A small number of hospitals in Ontario do not participate in HOOPP, having made other pension arrangements for their employees.
- Some hospitals offer Supplemental Employee Retirement Pension plans (SERPs) to their CEOs. SERPs are sometimes provided to individuals who are not members of HOOPP – for example, a physician or someone from outside the province who is recruited to be CEO.

Perquisites for hospital executives can include provisions such as automobile lease or car allowances for business travel, education allowances, discretionary spending amounts for business-related expenses, parking, payment of healthcare and other insurance premiums, professional memberships, home computers and mobile phones. Hospital boards decide whether to provide such perquisites based on market analysis and business requirements. As stated above, the Ontario Government's directive of August 2, 2011, prohibited some perquisites and stipulated that all others be business-related requirements for the effective performance of an individual's job.

Other Compensation: Hospital boards may negotiate other forms of compensation with their CEOs, including severance arrangements and retention bonuses.

5. Hospital Executive Compensation in Other Jurisdictions

The Panel reviewed models for executive compensation in other provinces and countries (Appendix B). The Panel concludes that it is difficult to compare Ontario with other jurisdictions given the many differences among hospital systems. As noted, Ontario is the only province in Canada in which local autonomous boards determine compensation guidelines and pay standards for healthcare executives. Its population is significantly larger than those of other provinces.[9] Furthermore, its largest hospitals are complex organizations that provide highly specialized care, conduct world-class research, and educate large numbers of future medical and healthcare professionals. Although Ontario's per capita hospital expenditure is the second lowest in Canada, its hospitals perform well based on standard wait time measures and other indicators.

[9] As of July 1, 2011, Ontario's population was 13,373,000, compared to Alberta with 3,779,400, British Columbia with 4,573,300, and Quebec with 7,070,000 (Statistics Canada, CANSIM).

Part B: The Panel's Deliberations

1. Are Current Compensation Levels Provided to Ontario Hospital CEOs Appropriate?

The Panel assessed the appropriateness of current executive compensation levels in Ontario hospitals by analyzing the competitive markets in which hospitals operate. The analysis considered three competitive markets: hospitals, other public sector organizations, and the private sector. (See Appendix C for the Panel's data sources.)

i. Comparing Ontario Hospitals with One Another

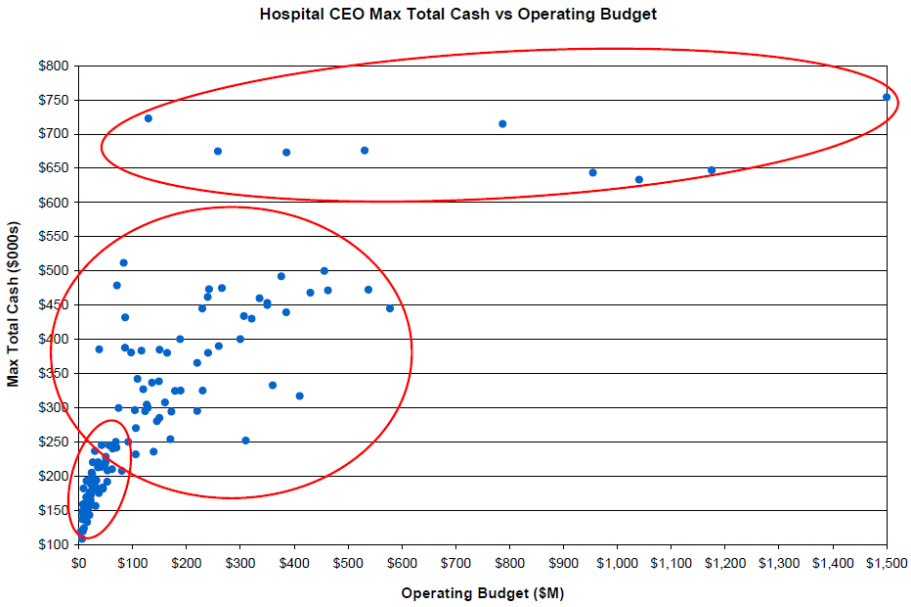
The Panel compared the base salaries of Ontario hospital CEOs by hospital size, as defined by revenues (see Appendix D). The analysis showed that CEO annual total cash compensation generally correlates positively with hospital revenues (Figure 6). However, a more detailed analysis revealed some variations in this relationship:

- CEOs of hospitals with revenues under $25 million earn lower incomes.
- CEOs of mid-size hospitals (revenues between $25 million and $250 million) have highly variable incomes that are poorly correlated to differences in hospital revenues.
- CEOs of larger teaching hospitals with budgets of $250 million or more tend to have fairly similar incomes. It appears that once hospitals reach this size, further increases in their revenues have little impact on CEO compensation.

Interviews conducted by Mercer on behalf of the Panel indicate that boards tend to consult the OHA's annual executive salary survey and the public sector salary database in determining CEO compensation. When a board selects a comparator group of hospitals, it appears to set its targeted pay position above the median of the comparator group. This practice likely results in a continuous upward creep in CEO compensation levels at mid-size hospitals. The Panel concludes that a board's decision to use a particular comparator group may be inappropriate if differences in compensation cannot be explained by differences in the scope and complexity of the hospital.

The generally positive correlation between CEO compensation and hospital revenues is appropriate and expected. Given the inconsistencies that become apparent through closer analysis of the data, however, the Panel believes that hospitals would benefit from a standardized framework for setting CEO compensation that takes into account a number of quantitative and qualitative factors beyond simply hospital revenues.

Figure 6: Ontario Hospital CEO Annual Total Cash Compensation by Operating Budget, 2011



Source: OHA Executive Compensation and Benefits Survey conducted by Mercer for the Panel. September 2011.

ii. Comparing Ontario Hospitals with Other Public Sector Organizations

There are significant differences in the size and scope of Ontario public sector organizations. Compensation levels for CEOs of Ontario's largest hospitals tend to be comparable to those of university presidents and heads of other large public sector organizations (Figure 7). Among a representative group of 51 public sector organizations in Ontario, the median CEO (or equivalent) compensation in 2010 was approximately $266,000, which is similar to the pay range found within mid-size hospitals (Appendix D).[10] The median pay of a university president is slightly higher. According to Mercer, the use of performance pay varies significantly by public sector organization.

The Panel concludes that CEO compensation in large hospitals aligns well with executive compensation in other large public sector organizations using the test of reasonableness. Governments establish and fund public sector organizations to address major areas of public importance and to secure specialized skills with the expectation that high-calibre leaders will be hired and compensated accordingly. This appears to be the case.

Although there is significant alignment between CEO salaries in hospitals and the broader public sector, the Panel concludes that the public sector is not a reliable ongoing

[10] The median is the middle case or midpoint.

comparator for hospitals for two reasons: there are relatively few public sector organizations in Ontario and those that do exist vary significantly in size and scope.

Figure 7: Salaries for CEOs of Large Ontario Public Sector Organizations, 2010

Employer	Salary Paid*
Ontario Power Generation	$1,325,119
Hydro One	$953,844
University Health Network	$753,992
St. Joseph's Health Care, London & London Health Sciences, London	$732,615
The Hospital for Sick Children	$702,000
University of Toronto, Asset Management Corporation	$697,020
Mount Sinai Hospital	$689,025
Sunnybrook Health Sciences Centre	$687,968
Baycrest Centre for Geriatric Care	$685,766
St. Joseph's Health System	$649,486
The Ottawa Hospital	$642,071
Hamilton Health Sciences	$622,777
University of Ottawa Heart Institute	$612,037
Independent Electricity System Operator	$601,892
Toronto Rehabilitation Institute	$585,599
Centre for Addiction & Mental Health	$584,999
Ontario Financing Authority	$557,623
St. Michael's Hospital	$554,750
Cancer Care Ontario	$520,678
Ontario Energy Board	$517,619
Humber River Regional Hospital	$498,631
Trillium Health Centre	$492,960
Bridgepoint Hospital	$487,432
Ontario Pension Board	$485,801
Kingston General Hospital	$482,285
York University	$480,030
St. Joseph's Healthcare Hamilton	$478,847
Holland Bloorview Kids Rehabilitation Hospital	$478,572
Halton Healthcare Services	$474,796
Southlake Regional Health Centre	$472,615

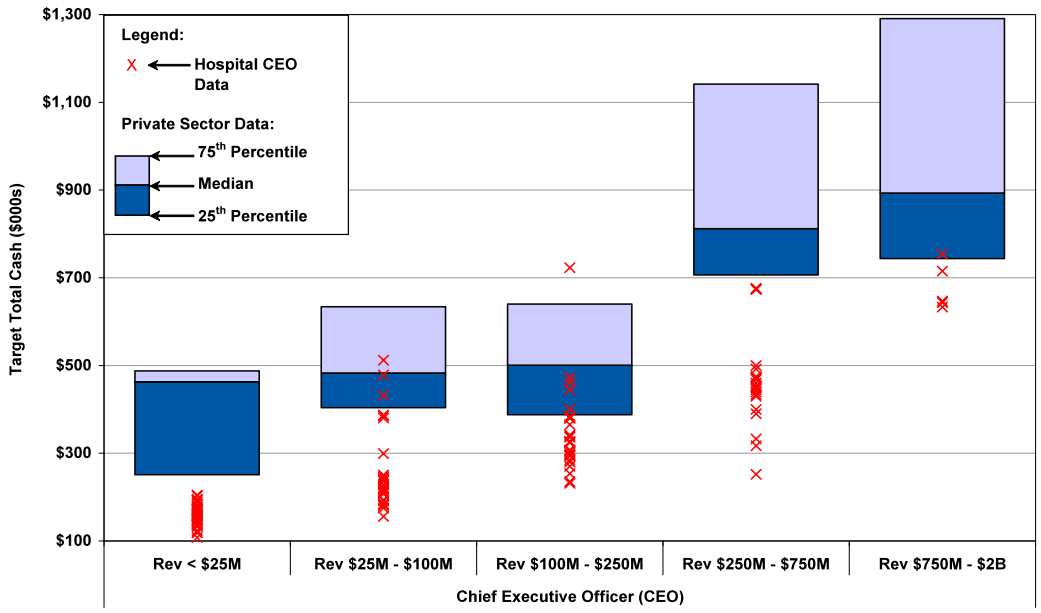
Employer	Salary Paid*
Huron University College	$469,837
Lakeridge Health	$458,921
Rouge Valley Health System	$456,433
Ontario Realty Corporation	$453,164
Ontario Shores Centre For Mental Health Sciences	$452,198
St. Joseph's Health Centre, Toronto	$451,499
Credit Valley Hospital	$450,388
The Scarborough Hospital	$450,005
University of Guelph	$440,590
Women's College Hospital	$439,091
Ontario Agency for Health Protection & Promotion	$435,407
University of Western Ontario	$440,000
Liquor Control Board of Ontario	$431,403
Toronto East General Hospital	$425,001
Grand River Hospital	$424,624
North York General Hospital	$416,305
Markham Stouffville Hospital	$410,215
Thunder Bay Regional Health Sciences Centre	$407,458
Metropolitan Toronto Convention Centre Corporation	$397,000
University of Ottawa	$395,000
Queen's University	$382,800
Providence Healthcare	$391,242
York University	$385,547
St. John's Rehab Hospital	$382,913
West Park Healthcare Centre	$381,225
University of Toronto	$380,100
Children's Hospital of Eastern Ontario	$373,840
Cambridge Memorial Hospital	$373,750
Workplace Safety & Insurance Board	$369,281
Runnymede Healthcare Centre	$369,026

* Released April 2011. Data may include partial year salaries and severances.
Source: Ontario Ministry of Finance, 2010, as compiled by Mercer, September 2011.

iii. Comparing Ontario Hospitals with Private Sector Organizations

The Panel compared the compensation of CEOs in hospitals and private sector organizations of comparable size as defined by revenues. (Hospital revenues were defined as total operating budget including research funds.) Figure 8 presents total cash compensation for hospital and private sector CEOs, including base salary plus additional annual cash compensation (e.g., bonus, variable or performance pay). Note, however, that the compensation levels shown for private sector CEOs do not include long-term share-based incentive plans.

Figure 8: Annual Total Cash Compensation, Hospital and Private Sector CEOs



Source: Hospital CEO compensation data from OHA Executive Compensation and Benefits Survey conducted by Mercer for the Panel, September 2011. Private sector data taken from existing Mercer database.

Annual total cash compensation for hospital CEOs is generally below the 25th percentile of CEOs in the private sector. (In other words, three-quarters of the CEOs at comparably sized private sector organizations earn more than their hospital counterparts.) This is clearly the case at the smallest hospitals and at larger hospitals with revenues of $250 million or more. On the other hand, CEO compensation in hospitals with revenues between $25 million and $250 million varies widely, from well below the 25th percentile to the median of the private sector and, in a few cases, above the median (Appendix D).

Generally speaking, hospital CEO compensation in Ontario appears to be reasonable relative to the compensation of private sector CEOs in organizations of comparable size. The wide range of compensation levels at mid-size hospitals, however, highlights the need for a more consistent approach to determining hospital CEO compensation.

iv. Hospital CEO Perquisites, Pensions and Other Compensation Arrangements

The Panel did not analyze perquisites in great detail given Ontario's recent decision to impose restrictions on perquisites in the broader public sector. The Panel did note, however, that according to Mercer the average annual value of perquisites provided to Ontario hospital CEOs is approximately $16,000. The most common perquisites are a monthly car allowance, business club memberships, relocation costs, outplacement

counselling and a business travel allowance. Based on its discussions with Mercer, the Panel concludes that the average annual value of perquisites is reasonable compared to the private sector.

With regard to pensions, 117 of the 126 hospitals that took part in a survey conducted by Mercer on behalf of the Panel reported that their CEOs participate in the Healthcare of Ontario Pension Plan (HOOPP). Thirteen of the 126 hospitals – mostly larger hospitals – reported that they provide their CEOs with a Supplemental Employee Retirement Pension Plan (SERP). At four hospitals, the CEO belongs to HOOPP and is also covered by a defined contribution SERP, for which the hospitals' contributions vary from less than $50,000 to over $200,000 a year [11]. At five hospitals at which the CEO is not covered by HOOPP, he or she is covered by a defined benefit SERP.[12]

The Panel recognizes that a SERP can be a useful tool in recruiting a preferred CEO candidate who does not qualify for a full pension under HOOPP. The Panel concludes that this practice is reasonable, provided that details of the SERP are publicly disclosed. Currently, hospitals are not required to disclose SERP arrangements.

Hospital CEO contracts can include a number of other arrangements that are negotiated between hospital boards and their CEOs. The most common such arrangement is severance: the vast majority of the contracts reviewed by Mercer included arrangements for severance pay in the event that the CEO is dismissed without cause. The severance provisions in these contracts generally start at 12 months' pay, escalating by one month per year of service to a maximum of 18 months, or start at 18 months and build to 24 months. The median is close to 18 months. The Panel assessed these severance arrangements in relation to best practices in the private sector to determine a reasonable approach.

2. Have Recent Legislative Requirements Impacting Executive Compensation Achieved the Desired Outcomes and Supported the Objectives and Strategies of Ontario Hospitals?

The Panel reviewed the impact of recent Ontario Government requirements on hospitals and hospital executive compensation:

- *Bill 16* put a two-year freeze on non-bargaining compensation in the Ontario Public Service and the broader public service.
- *Bill 46* required hospitals to develop annual Quality Improvement Plans and link a portion of executive compensation to performance improvement targets set out in the QIP.

[11] A defined contribution pension is a retirement investment plan in which the employee's contributions (which the employer usually matches) are fixed, usually based on a percentage of the employee's salary. The level of benefits paid to the employee after retirement will depend on how well the portfolio performs.
[12] A defined benefit plan provides fixed retirement benefits based on a formula that typically takes into account years of service and average salary over a specified period, such as the last five years of employment.

- *Bill 122* subjects hospitals to Ontario's *FIPPA*.
- *Bill 173* enabled a Management Board of Cabinet directive eliminating some perquisites and limiting others.
- *The 2011 Ontario Budget* signalled the province's intention to reduce permanently funding for hospital executive offices by 10% over two years.

Bill 16 appears to have resulted in significant compression of compensation between non-bargaining and bargaining unit employees. This is especially the case in smaller hospitals where unionized employees who are at the top of their salary range and who collect substantial overtime pay can earn close to the salary of a hospital executive. Compensation compression also occurs in all other hospitals between front-line management and front-line staff. Salary compression tends to discourage individuals (including doctors and nurses) from taking on leadership positions for which the financial rewards are minimal and the quality of life trade-offs are significant. This may become a significant attraction and retention issue based on hospital leadership demographics across the province.

Before the enactment of *Bill 46*, about 30% of Ontario hospitals – mostly the larger teaching centres – had implemented some form of pay-for-performance for their CEOs and other members of the executive team. Although all hospitals must now include performance pay in executive compensation, the extent to which they have done so varies greatly; performance measures, weightings and targets differing widely across hospitals. The CEO's performance incentive generally ranges from about 2 percent to less than 10 percent of base pay. There are some notable exceptions, however – mainly large teaching hospitals where pay-for-performance ranges as high as 30% of base pay.

Hospitals that voluntarily implemented performance pay before *Bill 46* appear to have achieved a high degree of alignment between hospital priorities and compensation outcomes. In contrast, hospitals that introduced pay-for-performance in response to *Bill 46* have struggled to identify performance expectations and to introduce performance-based compensation while at the same time complying with a two-year salary freeze for non-unionized employees. At these hospitals, performance pay tends to account for 5 percent or less of total executive compensation. As well, a number of hospitals have set unambitious quality improvement targets, in some cases below existing performance levels. For these hospitals, the pay-for-performance requirement combined with the salary freeze effectively resulted in a reduction in base salaries.

The Panel observes that recent mandated changes in hospital compensation practices appear to have hurt morale and made it more difficult for hospitals to attract qualified senior managers. This is especially a concern in smaller hospitals at which there is significant salary compression. In addition to difficulties attracting and keeping hospital leaders, these hospitals may face significant turnover and destabilization due to the pay freeze that applies to non-union front-line employees. Although the Panel believes the focus on quality improvement plan metrics is appropriate, the implementation of these plans varies widely. As a result, the effectiveness and impact of quality improvement measures may vary significantly.

The Panel strongly supports pay-for-performance as an effective way to drive hospital and system improvements. Although the Panel applauds the Government's desire to link compensation with performance, it concludes that the salary freeze and resulting compression, coupled with the lack of a strategic and coordinated approach consistently applied to all hospitals, has undermined the intended outcome. In addition, the changes have encroached on the responsibilities and accountabilities of autonomous hospital boards.

Part C: The Panel's Recommendations

1. Hospital Executive Compensation Framework

Hospital CEO salaries have always come under public scrutiny. This is especially true now given concerns about Ontario's economy and the rising cost of health care. The provincial deficit was $14 billion in the 2010/11 fiscal year.[13] The Government's stated intention to eliminate the deficit in six years means that all publicly funded organizations will face difficult budgetary pressures.

The Panel notes that hospital CEO compensation currently accounts for about 0.2% of all hospital expenditures. Some commentators have suggested that Ontario hospital CEO salaries should be limited to $418,000 a year (double the Premier's salary). Three-quarters (75%) of Ontario's hospital CEOs currently earn less than this amount. Those who earn more tend to run larger community hospitals or complex academic health science centres. These centres provide a wide range of services on multiple sites, serve the region and province (and, in a number of cases, the country as a whole), partner with more than one hospital foundation, educate medical and other healthcare students, and conduct world-leading research. Of Canada's top five research hospitals, four are located in Ontario: University Health Network (1), Hamilton Health Sciences (2), The Hospital for Sick Children (3), and Sunnybrook Health Sciences (5).[14]

Each of Ontario's 151 hospitals is vital to its community. Ontario's hospitals appear to be highly efficient compared to their counterparts in other provinces. At the same time, they continue to provide high levels of care as measured by national wait time benchmarks for selected procedures. The Panel believes that hospital leadership is an important contributor to this success. Ontario hospital CEOs share an impressive array of management and clinical education credentials, as well as extensive experience.[15]

Excellent leaders have a significant positive impact on the effectiveness and productivity of hospitals, on the quality of patient care, and on the ability of hospitals and the healthcare system to meet the evolving needs of Ontarians. Competitive and reasonable compensation is essential to attract the high quality leadership that Ontario hospitals need.

To ensure that CEO compensation stands up to public scrutiny, is set at reasonable levels to attract and retain quality leadership, and supports a reliable degree of comparability among hospitals, the Panel recommends that Ontario hospital boards use a standardized Hospital Executive Compensation Framework to determine CEO compensation. The

[13] Ontario Ministry of Finance. 2011 (August). 2010-2011 Public Accounts of Ontario Annual Report and Consolidated Financial Statements; page. 9.
[14] RE$EARCH Infosource Inc. 2011. Top 40 Research Hospitals List 2011 (http://researchinfosource.com/). Generally, data were obtained through a survey of research hospitals. Data were not obtained from institutions in Alberta, Saskatchewan, New Brunswick, Prince Edward Island and Newfoundland. The Panel observes that Alberta is the only non-participant that has significant hospital research.
[15] See Appendix E for survey results of the leadership qualifications of Ontario hospital CEOs.

Panel recognizes that hospitals would not be legally bound to use such a Framework; failure to do so, however, might result in increased Government intervention.

Recommendation One

Ontario hospital boards of directors should use a standard Hospital Executive Compensation Framework to determine compensation for their senior hospital executives.

The Framework should be developed by the OHA in consultation with its members based on the following underlying principles:

1. Ontarians have a right to expect that hospitals will be run effectively and efficiently, and that ***common standards of care and performance*** will be achieved.[16]

2. Each hospital's strategic priorities should be supported by goals and clear ***accountabilities*** of the Board, CEO, Chief of Staff and other senior executives right through to the front line.

3. Executive ***compensation should be aligned with hospital priorities and objectives and reflect actual performance measured against these objectives***. Failure to meet performance standards should have consequences for hospital executive pay.

4. The public has the right to ***full disclosure*** of hospital performance and executive pay.

5. Total compensation for hospital executives should stand the ***test of reasonableness*** taking into account factors such as market competition, hospital size and complexity, while recognizing the public nature of the healthcare system.

6. The Framework should be sensitive to differences among hospitals, and ***provide hospital boards with the latitude to govern***.

i. CEO Total Cash Compensation

The total cash compensation of hospital CEOs appears to be reasonable compared with that of private sector CEOs in organizations of comparable size and complexity; in most cases it is below the 25th percentile of the private sector, controlling for organization revenues. The Panel notes that:

- Ontario needs to continue attracting highly skilled leaders to preserve the quality of its hospital public service.
- If Ontario hospitals are to attract and keep the best leaders, compensation must be appropriate and competitive. Although the Panel would not suggest hospital executive positions are interchangeable with their private sector counterparts, the Panel does

[16] These standards can reflect OHA's strategic indicators.

recognize that hospital CEO jobs are highly complex and demanding. This is especially true of Ontario's largest hospitals, many of which have become increasingly more complex as a result of amalgamations with other hospitals.
- Establishing a compensation reference point will provide a standard, consistent approach to hospital compensation. It will also provide hospital boards with the latitude to attract the most qualified candidates and tailor compensation to the complexity of the CEO's position.
- The private sector provides a large, reliable, stable and ongoing comparator for Ontario hospital CEO compensation due to the large number of private sector organizations.

Recommendation Two

The 25th percentile of private sector total cash compensation (excluding long-term incentive plans) should be used as a reference point to determine the total cash compensation for Ontario hospital CEOs, controlling for organization revenues.

ii. CEO Base Salary

In the Panel's opinion, hospital CEO base salaries should be determined using a standard compensation template that:

- Uses both quantitative and qualitative measures to rate each hospital (Table 1);
- Links the hospital rating to competitive market compensation data;
- Includes pay ranges for the consideration of hospital boards; and
- Incorporates current market data that is updated annually.

Table 1: Examples of Quantitative and Qualitative Factors to be Considered in a Standard Hospital Executive Compensation Template*

Quantitative	Qualitative
• Annual operating revenues • Number of discrete hospital sites • Number of specialty programs • Number of active physicians with hospital privileges • Teaching intensity • Research intensity • Rurality/distance • Regional programs • Number of staff	• Hospital catchment area (local, regional, provincial, national or international) • CEO responsibility for other healthcare entities • CEO engagement with workforce, community and/or hospital foundation(s) • Leadership development • System leadership roles
*Measures should be rank-ordered and weighted before being linked to pay.	

Target base salary levels should be expressed as ranges (minimum, midpoint, maximum) so that performance improvements can be recognized and appropriately compensated. The 25th percentile of the private sector should be used as a reference point to determine

the total cash compensation for Ontario hospital CEOs, controlling for organization revenues (Recommendation 2). Total cash compensation includes base salary and any pay-for-performance (see Figure 5 on page 9).

Hospital boards were created in Ontario to meet local needs, an important element of which is the flexibility to attract qualified hospital leaders. Given Ontario's support for the voluntary system of hospital governance, the Panel believes that boards should continue to have discretion to set compensation levels in accordance with the Framework we are proposing. The rationale for decisions and alignment to performance, however, should be transparent and publicly disclosed.

Recommendation Three

The Ontario Hospital Association, in consultation with its member hospitals, should develop a standard compensation template based on the Hospital Executive Compensation Framework for hospital boards to use in determining the appropriate level of CEO base salary.

iii. Pay for Performance

The Panel strongly supports pay-for-performance as an effective way to drive hospital and system improvements. Pay-for-performance enables hospitals to link and align their priorities to compensation. It also provides an opportunity to earn additional compensation for delivering on key strategic priorities. Hospitals are familiar with the pay-for-performance concept given that many of them receive annual funding to deliver agreed-upon volumes of priority procedures.

Ontario hospitals vary significantly in their pay-for-performance measures, weightings and targets. In the Panel's opinion, a consistent approach is needed with all hospitals expected to implement a minimum level of pay-for-performance for the CEO within a defined period. The Panel concludes that a range of 10% to 30% of base pay, to be implemented within three years, is reasonable. Performance pay should be linked to the achievement of hospital strategic priorities and hospital performance improvement targets as noted in the Quality Improvement Plan. The hospital's strategic priorities and performance improvement targets should be established by the CEO and the Board, with input from others in the hospital and aligned with the fiscal year.

The Panel notes that pay-for-performance should be integrated into the Executive Compensation Framework (Recommendation 3). Over time, all senior management – including Vice-Presidents, Directors and Clinical Chiefs – should have a pay-for-performance component as part of their total compensation.

Recommendation Four

All Ontario hospitals should implement within three years a pay-for-performance program for their CEO, ranging from 10% to 30% of base pay. Performance pay should be linked to achieving hospital strategic priorities and hospital performance improvement targets as set by the Quality Improvement Plan.

iv. Hospital CEO Perquisites, Pensions and Other Compensation Arrangements

The Panel does not make recommendations on perquisites and SERPs given that, in its view:

- The average annual value of perquisites is reasonable compared to the private sector.
- Providing a Supplemental Employee Retirement Pension Plan (SERP) as a recruitment tool in selected instances is reasonable provided that the details of such plans are publicly disclosed.

With regard to severance, there appears to be a wide variance of severance agreements for hospital CEOs. The Panel assessed these in relation to best practices in the private sector and supports the use of a standardized approach.

Recommendation Five

Ontario hospital CEO severance agreements (for termination without cause) should be standardized according to best practice and legal precedent.

v. Full Public Disclosure of Hospital Compensation and Performance

The public has a right to information about hospital executive compensation and performance. The information that is currently available under Ontario's *Public Sector Salary Act* (the so-called "Sunshine List") has limitations, including:

- The list reports T4 taxable income earned in a specific calendar year, rather than the current annual salary;
- T4 income amounts may include onetime payments such as bonuses, retroactive or severance pay;
- The reported data may understate the annual salary of someone who is hired or leaves within the calendar year;
- Only taxable benefits on the employee's T4 slips are reported; other components of the benefits package (such as SERPs and deferred income) are excluded.

In the Panel's opinion, all hospitals should provide information on their hospital executives' compensation using a standard format that includes, but is not limited to, the following:

- Disclosure of compensation earned (base salary, pay-for-performance, pension contributions, perquisites and other compensation);
- Pay-for-performance targets and achievement;
- Linkage of performance to annual compensation changes;
- Employment contract terms and provisions; and
- Severance arrangements.

Recommendation Six

The Ontario Hospital Association, in partnership with its member hospitals, should develop a standard form that includes comprehensive compensation information for hospital CEOs and senior executives. All hospitals should be required to post this information on their respective websites in a timely fashion. The OHA should use outside expertise as necessary to perform this task.

vi. Supporting Changes to Compensation Practices

Not all hospital boards and executive leaders across Ontario are ready and able to adopt a pay-for-performance compensation model. Many hospitals have limited processes for setting goals and managing performance against these goals. Boards need to be well trained and have access to ongoing support as they implement the Executive Compensation Framework. Smaller hospitals in particular have fewer resources to help with the transition and may face more public scrutiny than larger hospitals in urban areas. The OHA must play a strong leadership role by training and supporting its member hospitals.

Recommendation Seven

The Ontario Hospital Association should develop education programs and provide coaching for hospital board members and executive leaders who require assistance in transitioning to a comprehensive pay-for-performance approach as part of their compensation practices. This includes developing competencies to implement the Executive Compensation Framework and its key components (compensation competitiveness, pay-for-performance, enhanced public disclosure). The OHA should use outside expertise as necessary to perform this task.

The Panel believes that hospital boards should develop and implement executive compensation policies that include performance targets not just for the CEO but other senior executives and Chiefs of Staff as well.

Recommendation Eight

Hospital boards should be responsible for approving the compensation policies that apply to the direct reports of the CEO.

2. Consolidated Recommendations

The Panel recommends that:

R1 Ontario hospital boards of directors should use a standard Hospital Executive Compensation Framework to determine compensation for their senior hospital executives.

R2 The 25th percentile of private sector total cash compensation (excluding long-term incentive plans) should be used as a reference point to determine the total cash compensation for Ontario hospital CEOs, controlling for organization revenues.

R3 The Ontario Hospital Association, in consultation with its member hospitals, should develop a standard compensation template based on the Hospital Executive Compensation Framework for hospital boards to use in determining the appropriate level of CEO base salary.

R4 All Ontario hospitals should implement within three years a pay-for-performance program for their CEOs, ranging from 10% to 30% of base pay. Performance pay should be linked to achieving provincial priorities, hospital strategic priorities and hospital performance improvement targets as set by the Quality Improvement Plan.

R5 Ontario hospital CEO severance agreements (for termination without cause) should be standardized according to best practice and legal precedent.

R6 The Ontario Hospital Association, in partnership with its member hospitals, should develop a standard form that includes comprehensive compensation information for hospital CEOs and senior executives. All hospitals should be required to post this information on their respective websites in a timely fashion. The OHA should use outside expertise as necessary to perform this task.

R7 The Ontario Hospital Association should develop education programs and provide coaching for hospital board members and executive leaders who require assistance in transitioning to a comprehensive pay-for-performance approach as

part of their compensation practices. This includes developing competencies to implement the Executive Compensation Framework and its key components (compensation competitiveness, pay-for-performance, enhanced public disclosure). The OHA should use outside expertise as necessary to perform this task.

R8 Hospital boards should be responsible for approving the compensation policies that apply to the direct reports of the CEO.

Appendices

Appendix A: Terms of Reference for the Independent Expert Panel on Executive Compensation in the Hospital Sector

Rationale:

- Good leadership is imperative to the sustainability and quality of patient care of the Canadian healthcare sector. Good leaders have a significant impact on productivity and effectiveness of the healthcare system, in general, and the hospital sector, in particular. The hospital sector needs to remain competitive regarding compensation to attract and retain leaders who can provide good leadership.

Mandate:

- The Independent Expert Panel on Executive Compensation in the Hospital Sector will make recommendations to the Ontario Hospital Association on appropriate long-term compensation policy and practice guidelines for the range of hospital organizations that exist within the Province of Ontario.
- Final recommendations will be made to the Ontario Hospital Association.

Responsibilities:

The Panel will:

1. Examine existing executive compensation policies and practices[17] in Ontario hospitals, giving close consideration to the complexity and range of different organizations that exist in the province; [18]
2. Examine and consider leading governance practices and standards related to executive compensation within and outside of the health services industry; [19]
3. Confirm the leadership competencies required to lead and manage different hospital organizations; [20]
4. Assess the potential recruitment and retention impact, if any, of recent Ontario government policy decisions affecting hospital sector executive compensation;[21]

[17] From a total compensation perspective.
[18] Large academic hospitals with research missions and provincial/national/international mandates, large community hospitals, complex continuing care and rehabilitation hospitals, mental health and addiction hospitals, and small community hospitals serving rural and remote communities.
[19] For example, OHA Guidelines and Principles for Hospital Executive Compensation and the Institute for Corporate Directors standards for Compensation Committees.
[20] OHA's Leadership Development Institute Leadership Competencies for hospital Chief Executive Officers, Executives and Directors will be provided as a reference to the Task Force.
[21] Internal equity and compression of salary levels are examples of issues that appear to be emerging as a consequence of provincial government policy.

5. Conduct executive compensation benchmarking analysis of Ontario hospitals with national and international comparators within and outside the health services industry;
6. Make recommendations respecting appropriate guidelines for hospital sector executive compensation for use and adoption on a prospective basis by the hospital members of the Ontario Hospital Association; and
7. Make such other recommendations as are appropriate.

Membership:

- The Panel will consist of three to five individuals, including a Chair, appointed by the Executive Committee of the OHA Board of Directors.
- The Panel members shall be highly respected and independent.
- Members will serve without remuneration.[22]

Reporting Relationship:

- The Panel members will conduct their deliberations at an arm's length to the OHA.
- Final recommendations will be provided to the Ontario Hospital Association Board of Directors through the OHA President & CEO.

Decision-Making:

- Decisions will be made by consensus. The majority of the members will constitute a quorum.

Frequency of Meetings:

- The Panel shall meet at the call of the Chair. Meetings may be held by teleconference.[23]

Professional Support:

- A professional services firm with expertise in the area of executive compensation will be competitively selected to support the Panel.
- The Chief Human Resources Officer & Vice President, Health Human Resources Leadership of the OHA will provide lead staff support to the Panel.[24]

Approved by the Ontario Hospital Association's Board of Directors' Executive Committee: May 30, 2011.

[22] Reasonable and actual business and travel expenses will be reimbursed.
[23] The Expert Panel met nine times from July 20, 2011 to November 11, 2011 (July 20, July 21, August 11, August 24, September 14, September 22, October 20, October 31, November 3).
[24] OHA staff are not members of the Panel.

Appendix B: Hospital Executive Compensation in Other Jurisdictions

This information was collected for and provided to the Expert Panel by Mercer (Canada) Limited.

Practices in Other Provinces: Alberta, British Columbia and Quebec

Ontario is the only province where compensation guidelines and/or pay standards for healthcare executives are not determined by the provincial government or Regional Health Authorities. Some of this may be understood by the fact that other provinces structure their health services differently with Ontario maintaining a local system of hospital governance, as described above. As a point of comparison, it is noted that as of July 1, 2011, Ontario had 13,373,000 people, compared to Alberta with 3,779,400 people, British Columbia with 4,573,300 people, and Quebec with 7,070,000 people.[25]

Alberta's healthcare system – Alberta Health Services (AHS) – has one CEO who reports to the AHS Board. All hospitals fall within one of five geographic zones, each of which is led by a Zone Senior Vice-President who reports into the Executive Vice-President and Chief Operating Officer. Each hospital is led by a Site Director. The AHS Human Resources Committee approves the compensation of the CEO and the CEO's recommendations for the Executive Vice-Presidents. Vice-President level executives have pay-at-risk. Local hospital executive salaries fall within established salary bands.

In ***British Columbia***, CEO pay is determined through an executive compensation plan administered by the Health Employers' Association of BC. All health authorities use the same job evaluation plan and salary structure to set pay levels for all employees (including executives). The job evaluation plan includes 13 factors that reflect skill, effort, responsibility and working conditions. The salary structure reflects 20 levels of work with compensation increasing by level. The plan was developed in 1995 and is outdated since it was not designed for BC's current regionalised healthcare structure. Although there is no cap on CEO pay, government has to approve any adjustments to the plan.

Quebec has a provincial job classification system which is used to set CEO pay. The hospital sector has difficulties recruiting and retaining executive talent, in part because of language requirements and the draw from Ontario. Foundations generously support the compensation of CEOs in English speaking communities. Performance bonuses are typically used.

[25] Statistics Canada, CANSIM. Population as of July 1, 2011.

International Practices: Australia, United Kingdom, United States

Australia has a public system which has a strong private sector component. The state governments administer base salary ranges that reflect hospital groups by size and geography. Ranges in salary reflect the performance and capability of the CEO. Hospital boards have the authority to increase base salary up to 10% before they need government review. Variable performance pay of up to 10% is used in Victoria. Boards set targets and priorities which include State government priorities.

In the ***United Kingdom***, the National Health Service has hospitals managed by the government and by Foundation Trusts. An independent pay review body (Senior Salaries Review Body) advises on pay levels for government-managed hospitals, whereas a separate independent review body (Monitor) advises on the Foundation Trust hospitals. The pay structure includes fixed levels and reflects the scope and size of hospital. Annual performance bonuses (which are non-pensionable) for exceeding expectations are set at 5%.

The ***United States*** has a mix of three different hospital "systems:" not-for-profit, for-profit and faith-based hospitals. Local boards decide executive compensation levels. Not-for-profit hospitals are required to disclose CEO compensation to keep their not-for-profit status. Job evaluation does not appear to be common but incentive/performance pay is common.

Appendix C: Data Sources

1. OHA conducts an annual, voluntary salary survey of executive and senior management positions in Ontario hospitals. One hundred and four hospitals responded to the latest survey conducted in October 2010 by providing information on 16 jobs (salary, vacation and incentives).

2. In August 2011, a 2011 OHA Executive Compensation and Benefits Survey was developed to obtain up-to-date data in support of the Panel's work. Sponsored by the OHA, this custom survey was administered by Mercer on behalf of the Panel. On August 2, 2011, the survey was sent to Ontario's 151 hospital corporations. The survey asked for senior executive position information on compensation, retirements and savings plans, benefits and perquisites. Respondents were invited to provide additional comments that might be of value to the Panel. A total of 128 hospital corporations replied to the survey including all the large teaching hospitals in the province (85% response rate). Seventy four hospitals (49%) provided copies of their CEO contracts.

3. In September 2011, OHA sent a custom survey to all 151 hospitals asking for information on hospital executives including their management and clinical education, job experience, length of time working in healthcare and hospitals, and other relevant experience. A total of 123 hospitals responded to the survey. Since Ontario has only 140 hospital CEOs (some CEOs manage more than one hospital), this reflects an 88% response rate.

4. In August-September 2011, Mercer conducted 35 confidential interviews with Board Chairs, CEO, and the Vice-Presidents of Human Resources in 12 hospitals that reflected different sizes, complexities, types and locations across Ontario. The Panel received aggregate data of the findings. The consultations obtained opinions on executive compensation practices, the issues and challenges facing hospitals, and the impact of these on compensation for senior leaders.

5. Mercer conducts a wide range of compensation and benefit surveys and reviews, across Canada and internationally. This information was used to compare compensation and incentives received by hospital executives in Ontario, and executives working in other public sectors and the private sector. In addition, Mercer gathered information on the compensation practices of healthcare organizations in other provinces and internationally, other public sectors in Ontario, and the broader private sector. This information was used to compare and assess hospital compensation practices in Ontario. A market analysis of pay competitiveness was conducted for the Panel's consideration. In addition, Mercer reviewed employment terms, severance arrangements and other contractual conditions prevalent within the industry for reasonableness and appropriateness relative to its experience.

Appendix D: Detailed Analysis of Compensation Competitiveness

Chief Executive Officer (CEO): Preliminary Compensation Data Results for the CEO

				Budget / Revenue ($Mill)			Base Salary						Target Total Cash						Target Total Direct			
Survey Position Title	**Data Source***	**Data Scope**	*Number of Obs*	*P25*	*P50*	*P75*	*P10*	*P25*	*P50*	*P75*	*P90*	% of Mkt[1]	*P10*	*P25*	*P50*	*P75*	*P90*	% of Mkt[1]	*P25*	*P50*	*P75*	% of Mkt[1]
Chief Executive Officer (CEO)	*Custom Survey*	*Budget < $25M*	34	$9	**$15**	$21	$118	$136	**$155**	$169	$184	57%	$120	$138	**$159**	$176	$193	34%	--	--	--	--
		Budget $25M - $100M	33	$36	**$50**	$70	$176	$189	**$213**	$243	$355	75%	$182	$194	**$220**	$250	$395	46%	--	--	--	--
		Budget $100M - $250M	30	$127	**$150**	$189	$260	$282	**$302**	$365	$402	90%	$268	$295	**$325**	$380	$457	65%	--	--	--	--
		Budget $250M - $750M	21	$310	**$360**	$430	$316	$382	**$423**	$450	$518	99%	$333	$430	**$453**	$492	$673	56%	--	--	--	--
		Budget > $750M	5	$955	**$1,040**	$1,175	--	$518	**$528**	$550	--	101%	--	$644	**$647**	$715	--	72%	--	--	--	--
	Ontario Public Disclosure	*Crown Agencies, Hydro One, OPG*	51	--	--	--	$173	$216	**$266**	$347	$518	--	--	--	--	--	--	--	--	--	--	--
		Universities	26	--	--	--	$202	$276	**$320**	$384	$452	--	--	--	--	--	--	--	--	--	--	--
	Proprietary	*Utilities*	--	--	--	--	--	$202	**$205**	$257	--	--	--	$269	**$308**	$373	--	--	--	--	--	--
	MBD	*Rev < $25M*	16	$10	**$14**	$20	$165	$222	**$272**	$312	$394	--	--	$251	**$463**	$488	--	--	$331	**$475**	$748	--
		Rev $25M - $100M	44	$35	**$53**	$78	$194	$242	**$285**	$398	$542	--	$293	$404	**$483**	$634	$748	--	$391	**$611**	$823	--
		Rev $100M - $250M	31	$130	**$156**	$200	$250	$306	**$335**	$396	$471	--	$340	$388	**$501**	$640	$797	--	$489	**$679**	$964	--
		Rev $250M - $750M	39	$374	**$486**	$639	$259	$370	**$426**	$502	$660	--	$602	$706	**$812**	$1,142	$1,845	--	$697	**$1,198**	$1,978	--
		Rev $750M - $2B	44	$987	**$1,221**	$1,448	$325	$395	**$520**	$660	$910	--	$448	$744	**$893**	$1,291	$1,718	--	$749	**$1,459**	$2,665	--
		Ontario	73	$82	**$500**	$1,795	$254	$329	**$475**	$685	$1,218	--	$351	$487	**$787**	$1,534	$2,661	--	$673	**$1,193**	$2,775	--

1) Represents the custom survey P50 (median) data point divided by the MBD P50 market data point.

2) Represents percentage of incumbents eligible for the incentive.

3) Represents the pay-at-risk portion, associated with the quality improvement plan ("QIP"), for incumbents that only have pay-at-risk plans.

4) Represents the short-term incentive, which includes QIP and other performance metrics, for incumbents that have variable compensation award plans.

*Data survey sources: 2011 OHA Executive and Benefits Survey ("Custom Survey"), 2011/2012 Mercer Benchmark Database ("MBD"), 2010/2011 Integrated Health Networks Survey ("IHN")

Chief Executive Officer (CEO): Preliminary Incentive Data Results for the CEO

				Budget / Revenue ($Mill)			QIP Only[3] (% of Base)				Short-Term Incentive[4] (% of Base)				Long-Term Incentive (% of Base)			
Survey Position Title	**Data Source***	**Data Scope**	*Number of Obs*	*P25*	*P50*	*P75*	Elig[2]	*P25*	*P50*	*P75*	Elig[2]	*P25*	*P50*	*P75*	Elig[2]	*P25*	*P50*	*P75*
Chief Executive Officer (CEO)	*Custom Survey*	*Budget < $25M*	34	$9	**$15**	$21	*76%*	2%	**3%**	5%	*9%*	--	**--**	--	--	--	**--**	--
		Budget $25M - $100M	33	$36	**$50**	$70	*58%*	2%	**3%**	5%	*33%*	7%	**15%**	18%	--	--	**--**	--
		Budget $100M - $250M	30	$127	**$150**	$189	*63%*	3%	**3%**	5%	*37%*	7%	**10%**	20%	--	--	**--**	--
		Budget $250M - $750M	21	$310	**$360**	$430	*43%*	3%	**5%**	5%	*57%*	10%	**20%**	25%	--	--	**--**	--
		Budget > $750M	5	$955	**$1,040**	$1,175	*0%*	--	**--**	--	*100%*	25%	**30%**	30%	--	--	**--**	--
	Ontario Public Disclosure	*Crown Agencies, Hydro One, OPG*	51	--	**--**	--	--	--	**--**	--	--	--	**--**	--	--	--	**--**	--
		Universities	26	--	**--**	--	--	--	**--**	--	--	--	**--**	--	--	--	**--**	--
	Proprietary	*Utilities*	--	--	**--**	--	--	--	**--**	--	--	25%	**30%**	30%	--	--	**--**	--
	MBD	*Rev < $25M*	16	$10	**$14**	$20	--	--	**--**	--	*85%*	18%	**50%**	55%	*69%*	40%	**75%**	121%
		Rev $25M - $100M	44	$35	**$53**	$78	--	--	**--**	--	*86%*	20%	**40%**	65%	*55%*	40%	**75%**	121%
		Rev $100M - $250M	31	$130	**$156**	$200	--	--	**--**	--	*84%*	34%	**43%**	62%	*57%*	40%	**75%**	121%
		Rev $250M - $750M	39	$374	**$486**	$639	--	--	**--**	--	*92%*	60%	**80%**	100%	*65%*	58%	**126%**	250%
		Rev $750M - $2B	44	$987	**$1,221**	$1,448	--	--	**--**	--	*91%*	50%	**60%**	100%	*76%*	58%	**126%**	250%
		Ontario	73	$82	**$500**	$1,795	--	--	**--**	--	*88%*	30%	**55%**	100%	*55%*	58%	**126%**	250%

1) Represents the custom survey P50 (median) data point divided by the MBD P50 market data point.

2) Represents percentage of incumbents eligible for the incentive.

3) Represents the pay-at-risk portion, associated with the quality improvement plan ("QIP"), for incumbents that only have pay-at-risk plans.

4) Represents the short-term incentive, which includes QIP and other performance metrics, for incumbents that have variable compensation award plans.

*Data survey sources: 2011 OHA Executive and Benefits Survey ("Custom Survey"), 2011/2012 Mercer Benchmark Database ("MBD"), 2010/2011 Integrated Health Networks Survey ("IHN")

Glossary:

Data Element	Definition
25th Percentile (P25)	The data point that is higher than 25% of all other data in the sample when ranked from low to high.
50th Percentile (P50)	The data point that is higher than 50% of all other data in the sample when ranked from low to high. Also known as the median.
75th Percentile (P75)	The data point that is higher than 75% of all other data in the sample when ranked from low to high.
Base Salary	The fixed amount of money paid to an employee by an employer in return for work performed. Base salary does not include benefits, pay for performance or any other potential compensation from an employer.
Custom Survey	2011 OHA Executive Compensation and Benefits Survey, in which 128 hospitals submitted data. Hospitals were grouped based on budget size.
MBD	2011/12 Mercer (Industry) Benchmark Database. Combines general industry modules into a single data source. Includes data from approximately 960 private sector organizations (base salary, incentive, and total direct compensation by position).
Mean	The sum of all data reported divided by the number of observations in the sample. Also known as the average.
Number of Obs.	Number of observations.
Ontario Public Disclosure/Proprietary	Enterprises and/or agencies owned by the Province of Ontario.
Target Annual Incentives	The target annual cash incentive for the position as a percentage of base salary, for all incumbents who are incentive eligible.
Target Total Cash Compensation	Current base salary and other guaranteed payments and incentives, for all incumbents in the sample whether or not they were eligible for incentives.
Target Total Direct Compensation	Current base salary, other guaranteed payments and incentives, and other long-term incentives, such as equity-based awards.

Appendix E: Leadership Qualifications and Experience of Ontario Hospital CEOs

In September 2011, hospital CEOs were asked to provide information on their management and clinical education, job experience, length of time working in healthcare and hospitals, and other relevant experience. A total of 123 hospitals submitted survey information on 115 CEOs.[26] The results indicate that hospital CEOs have an impressive array of management and clinical education credentials.

Of 115 CEOs:

- The vast majority have formal management education credentials including certificate/diploma/courses (26%), a Bachelor's degree (14%), a Master's Degree (55%) or a PhD (1%).
- 47% of hospital CEOs have clinical education credentials: 21% are trained as nurses, 10% as physicians and 16% as other clinicians (e.g., occupational therapy, physical therapy, medical lab technologist, advanced emergency medical care assistant, respiratory therapist, recreational therapist, social worker, etc.).

What Are Your Management Education Credentials?

Certificate/ Diploma/ Courses	Bachelor's Degree	Master's Degree	PhD	None	Total
30	16	63	1	5	115

What Are Your Clinical Educational Credentials?

RN	MD	Other Clinical	None	Total
24	12	18	61	115

Hospital CEOs appear to have long healthcare careers. Although the 115 CEOs reported being in their current role an average of 5.6 years, these CEOs have worked an average of 26 years in the health sector (in and out of Ontario).

Almost 40% of CEOs previously worked as a CEO, 25% had been a Chief Nursing Officer, Chief Operating Officer or Chief Financial Officer, and 24% were a Vice-President.

What Was Your Job Prior to Your Current CEO Role?

Manager	Director	VP	CNO/ COO/ CFO	Chief of Staff	CEO/ President	Other	Total
1	7	27	29	2	45	4	115

[26] Although Ontario has 151 hospitals, there are 140 hospital CEOs since six executives hold multiple CEO positions.

References

Ontario Hospital Association Briefings

Ontario Hospital Association. 2011 (February 24). *Bulletin: Communications Support Materials and Technical Briefing for Implementing the Quality Improvement Plan.*

Ontario Hospital Association. 2011 (March 21). *Bulletin: Updated Quality Improvement Plan FAQs and Request for Plan Submission to the OHA.*

Ontario Hospital Association. 2011 (July 7). *Bulletin: Independent Expert Panel on Executive Compensation in the Hospital Sector*.

Ontario Hospital Association Documents

Ontario Hospital Association. 2010 (December). *Executive Salary Survey Report.*

Ontario Hospital Association. 2011 (June). *Strategic Indicators Report: Results to June 30, 2011*.

Ontario Hospital Association. 2011 (October). *OHA Position Statement on Funding and Capacity Planning for Ontario's Health System and Hospitals.*

Ontario Hospital Association. nd. *The Changing Face of Ontario Healthcare: Provincial Government Spending Comparisons* (PowerPoint Presentation). Based on CIHI 2010 National Health Expenditure Report, November 2010.

Ontario Hospital Association, Governance Centre of Excellence. 2006 (February). *Guidelines and Principles for Hospital Executive Compensation* (Publication #411). Prepared for Use of OHA Member Hospital Boards and CEOs by HayGroup

Ontario Hospital Association, Leadership Development. 2008 (November). *Leadership Competencies Dictionary: Director Level*.

Ontario Hospital Association, Leadership Development. 2008 (November). *Leadership Competencies Dictionary: Executive Level*.

Ontario Hospital Association, Leadership Development. 2009 (January). *Leadership Competencies Dictionary: Chief Executive Officer Level*.

Other Resource Documents

Begun, JW., B Zimmerman and K Dooley. 2003. "Health Care Organizations as Complex Adaptive Systems." In Mick, SM and M. Wyttenbach (eds.) *Advances in Health* Care Organization Theory. San Francisco: Jossey-Bass, 253-288.

Bill 16: *Creating the Foundation for Jobs and Growth Act*, 2010.

Bill 46, *The Excellent Care for All Act*, 2010.

Broader Public Sector Perquisites Directive (Issued under the provisions of the Broader Public Sector Accountability Act, 2010). Issued by Management Board of Cabinet, August 2, 2011.

Golden, B. 2006. "Change: Transforming Healthcare Organizations." *Healthcare Quarterly* 10 (Special issue): 10-19.

Ontario Government. 2011 (January). *Quality Improvement Plan Guidance Document*. Developed in collaboration with hospitals, Local Health Integration Networks, the Ontario Health Quality Council, the Ontario Hospital Association, and the Ministry of Health and Long-Term Care.

Ontario Government. 2011. *Turning the Corner to a Better Tomorrow: 2011 Ontario Budget*. Toronto: Queen's Printer.

Plsek, P. 2003 (January 27-28). "Complexity and the Adoption of Innovation in Health Care". *Accelerating Quality Improvement in Health Care Strategies to Speed the Diffusion of Evidence-Based Innovations*. A conference held in Washington, D.C. Convened by National Institute for Health Care Management Foundation National Committee for Quality Health Care.

Reeleder, D., V Goel, PA Singer, DK Martin. 2006. "Leadership and priority setting: The perspective of hospital CEOs." *Health Policy* 79: 24-34.

Reiter, KL, GA Sandoval and GH Pink. 2009 (December). "CEO Compensation and Hospital Financial Performance." *Medical Care Research and Review* 66 (6): 725-738.

Rouse, WB. 2008. "Health Care as a Complex Adaptive System: Implications for Design and Management" (Article based on a presentation at the NAE Annual Meeting Technical Symposium, October 1, 2007). *The Bridge* Spring, 17-25.

The Health Foundation (The Evidence Centre). 2010 (August). *Complex Adaptive Systems: Research Scan*. London: The Health Foundation.

Wilson, CN and H. Stranahan. 2000 (November). "Organizational Characteristics Associated with Hospital CEO Turnover" *Journal of Healthcare Management* 45: 395-404.