Constituency Liaison Lobby Kit

HSA HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

@hsabc
info@hsabc.org
www.hsabc.org

THE TIPPING POINT: SHORTAGE OF HEALTH SCIENCE PROFESSIONALS IN PUBLIC HEALTH CARE

For years, British Columbia's health care system has struggled with shortages of Health Science Professionals (HSP) in the public sector.

Many British Columbians have never heard of these professions, nor could they describe the critical role they play in our public health care system. Despite this lack of public awareness, health care would not function without them.

It is not just doctors and nurses who save lives and care for British Columbians; it takes a whole team of health care professionals.

Health science professions include Physiotherapists, Respiratory Therapists, Diagnostic Medical Ultrasonographers, Medical Laboratory Technologists, Medical Imaging Technologists, and many more. In fact, there are over 70 specialized professions that are critical to the success of our public health care system – from prevention to diagnosis to treatment and rehabilitation - ensuring robust and reliable care for patients across British Columbia.

The specific reasons for shortages in these professions vary, but generally arise from recruitment and retention challenges ignored for more than a decade, including lack of provincial post-secondary training capacity, competition with the private sector, heavy workload, and professional burnout. It will come as no surprise that these challenges have been made worse by the COVID-19 pandemic.

The health care system has managed under these shortages for many years, but the situation has reached a tipping point and needs immediate attention:

- COVID testing in BC is limited by the severe shortage of Medical Laboratory Technologists.
- Current Health Science Professionals are burning out due to heavy workload and excessive overtime demands, accelerating the shortage problem.
- Other provinces are attracting BC Health Science Professionals with higher wages and signing bonuses.
- The private sector is luring away physiotherapists and other professionals with higher wages and more manageable caseloads.
- Ongoing work to reduce diagnostic and surgical wait times in BC is jeopardized by these shortages.

HEALTH SCIENCE PROFESSIONALS REPRESENT THE MAJORITY OF PROFESSIONS IN SHORTAGE IN HEALTH CARE

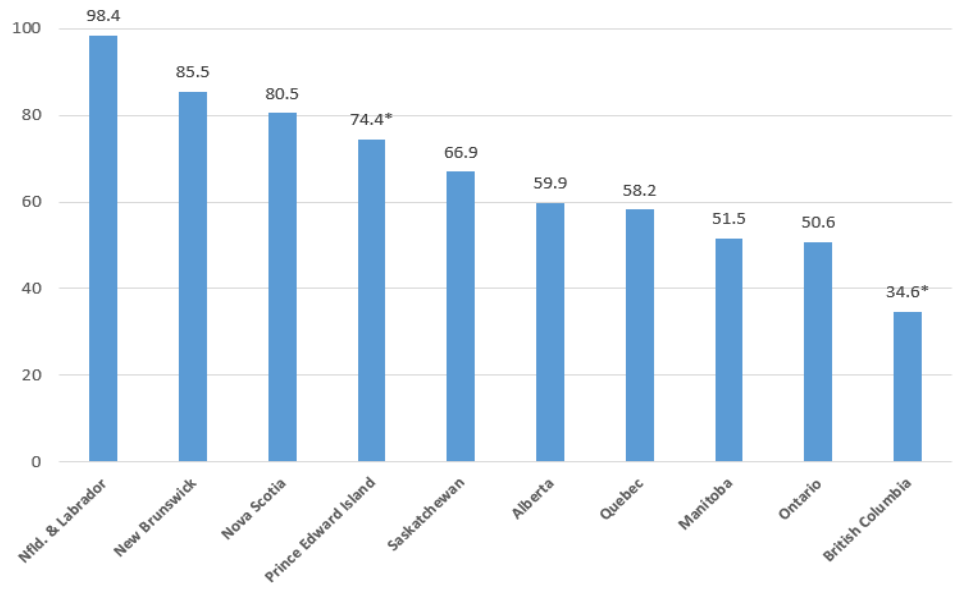
The BC Ministry of Health's Provincial Health Workforce Strategy 2018/19 – 2020/21 (see table at end of document) indicates that the majority of current and future priority professions with labour market challenges are in Health Sciences.

Because of unfilled vacancies and low staffing levels, many departments rely on overtime to deliver necessary services. For example, one respiratory therapy department in an acute care hospital can only manage demand using upwards of *1,800 to 2,000 hours of overtime each month* – and yet that department has vacancies that have remained unfilled for more than a year.

Based on available health authority data, unfilled vacancies for Occupational Therapists and Physiotherapists each increased by roughly 125% between 2014 and 2019.

Medical Laboratory Technologists are skilled professionals necessary for delivering COVID-19 test results, among other critical diagnostic tests. Yet, BC has the lowest number of Medical Laboratory Technologists per capita among the provinces. In 2019, BC had 35 MLTs per 100,000 people, significantly below all the provinces and the second-lowest, Ontario, with 51 per 100,000 people (Figure 1).

Figure 1: Medical laboratory technologists per 100,000 population, 2019



Source: Health Workforce Database, Canadian Institute for Health Information; Statistics Canada, Demography Division.
*Counts may be understated due to the non-regulatory status of the profession as of 2019. Please use with caution.

BC also faces a shortage of Respiratory Therapists, who are essential to caring for patients with COVID-19 and other cardio-respiratory conditions. Respiratory Therapists are specialized professionals who work with ICU teams to intubate patients, and they also play a vital role in hospital and outpatient settings in the areas of ventilator management, non-invasive ventilation therapies, respiratory assessments, management of patient oxygen needs, airway management, and patient education and self-management that supports discharge.

Alarmingly, BC has the fewest Respiratory Therapists per capita among the provinces (Figure 2). In fact, the number of Respiratory Therapists per capita declined between 2015 and 2019. BC was one of only two provinces to experience a decline in that period.

Figure 2: Respiratory therapists per 100,000 population, 2015 to 2019

	2015		2019		2019 rank per 100k	Change in RTs per 100k, 2015 to 2019
	Count	Number per 100,000	Count	Number per 100,000		
NB	369	48.6	429	55.7	1	14%
QC	4,143	50.7	4,404	52.5	2	4%
AB	1,677	40.5	1,895	44.0	3	9%
NS	289	30.9	346	36.0	4	17%
NL	141	26.7	162	30.8	5	15%
MB	328	25.0	331	24.5	6	-2%
ON	3,152	23.0	3,446	24.1	7	5%
SK	223	19.9	256	22.0	8	11%
PEI	25*	17.3*	31*	20.2*	9	17%
BC	950*	19.9*	979*	19.6*	10	-1%

Source: Canadian Institute for Health Information (2020), Canada's Health Care Providers, 2015 to 2019 (data tables).

Note: 2015 data for MB are unavailable and 2016 data have been used instead.

* Counts may be understated due to the non-regulatory status of the profession as of 2019. Use with caution.

The current shortage of Health Science Professionals is taking a toll. A 2021 survey of HSA members had some startling results: 57% said their department already has a patient waitlist; 76% reported shortages in their profession; and 82% are worried about patient care due to workload. Also notable: 70% said the pandemic has had a negative effect on their mental health.

Most concerning, 41% said they are considering leaving public practice due to unmanageable workload.

The current workload and stress on Health Science Professionals is not sustainable in the immediate, medium, or long term – either economically or in terms of human resources. It is expensive and causes burnout of the limited professionals we have.

Former governments ignored this growing crisis for decades, and we have now reached the tipping point.

SOME PROGRESS, BUT MORE GOVERNMENT ACTION IS REQUIRED

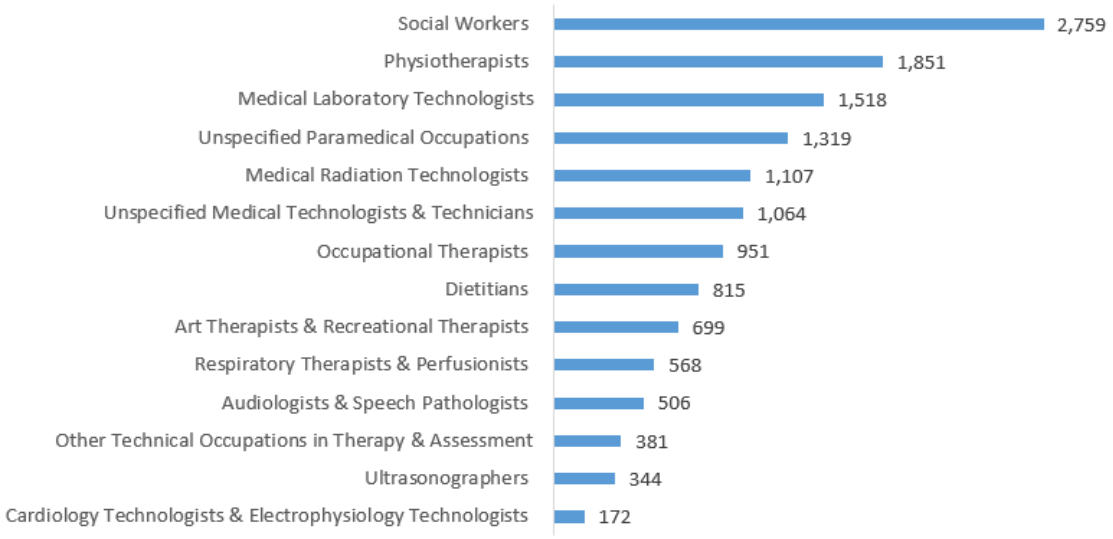
Many Health Science Professions are designated WorkBC High Opportunity Occupations, with thousands of job openings to be filled by 2029 (Figure 3). The vacancies are likely to increase as demand for health care increases as a result of COVID-19.

In 2019 government took some encouraging steps towards creating new training opportunities for Health Science Professionals, including 40 new first-year Physiotherapy and 24 Occupational Therapy training seats across the province;[1] and new Diagnostic Medical Ultrasonography training programs at College of New Caledonia in Prince George and at Camosun College on Vancouver Island.[2]

1 Ministry of Advanced Education, Skills and Training, Occupational and physical therapy seats coming to Northern BC, May 24, 2019. There are currently 80 first-year physiotherapy seats in BC. This will increase to 120 first-year spaces, with full expansion expected by September 2022. The First 20 seats will be at UBC Vancouver, followed by Fraser Valley. The most recent increase was in 2008. In occupational therapy, there are 48 first-year seats in BC. This will increase to 72 first-year seats with the first eight at UBC Vancouver (Sep. 2020) and 16 through a joint UBC/UNBC initiative (Sep. 2022). The most-recent increase was in 2009.

2 Ministry of Advanced Education, Skills and Training, Northern B.C.'s First Sonography Program Gets Underway, Jan. 28, 2019; Ministry of Advanced Education, Skills and Training, First sonography program coming to Vancouver Island, October 17, 2019.

Figure 3: WorkBC Job Openings, 2019 to 2029.



These are important steps, but we need to immediately increase post-secondary training opportunities for critical Health Science Professions facing severe shortages to ensure we have the specialized professionals needed to sustain our public health care system

Budget 2021 provided $96 million in new funding over three years to support expansion of post-secondary training capacity for nurses and health science professionals. Although details of the post-secondary seat expansion are not yet available, without significant commitment to expansion of training for health science professions, no headway will be made in the medium and long term on addressing the shortages.

In addition, the BC government continues to build its workforce planning expertise through the creation of the Allied Health Policy Secretariat in the Ministry of Health, which recently completed the first-ever survey of the allied health workforce. We applaud the Ministry for engaging frontline professionals about severe shortages, heavy workload, and lack of career advancement and leadership opportunities. We now need action on those findings.

However, increased training alone will not be enough. We must be thinking about innovative incentives to bring new graduates into public health care, and strategies to maintain and increase existing staffing levels.

One of the most profound challenges is that many Health Science Professionals can earn more and carry lighter workloads in the private sector.

This is a real threat to our public health care system. For example, in 2019 BC had the smallest share – 33%– of Physiotherapists working in the public sector among the provinces with available data (Table 4). More concerning is that over time, a smaller and smaller share of total Physiotherapists in BC are working in the public sector. According to the Canadian Institute for Health Information, between 2010 and 2019, the share of Physiotherapists in the public sector declined from 48% to 33%.

This indicates the significant competition we face with the private sector in BC for trained health professionals.

Table 4: Percentage of Physiotherapy Workforce by Sector of Employment, 2019

	% in public sector	% in private sector
Saskatchewan	53%	44%
Newfoundland and Labrador	52%	48%
Manitoba	48%	48%
Alberta	47%	52%
New Brunswick	42%	56%
British Columbia	33%	64%

Source: CIHI, 2020

Note: Provinces with available data are included. Percentages may not sum to 100% as some data do not specify sector. Private sector includes self-employed.

In the short- to medium-term we urge the government to consider a range of recruitment and retention strategies to address this crisis.

These include signing bonuses to recruit professionals currently not practicing in the public system or from other jurisdictions; student loan forgiveness for new graduates who commit to working in public health; travel and relocation expense reimbursements (as many vacancies are in rural and remote communities); and housing stipends.

It is also important to recognise that BC lags behind other provinces when it comes to wages for Health Science Professionals (Table 5). BC is often in the middle or at the bottom of the pack in terms of compensation, especially compared with neighbouring Alberta. We also know that while many young professionals may train in BC, they quickly relocate to other provinces due to the lower cost of living and higher pay.

Table 5: Selected BC health science professions by wage gap with Alberta

	BC Public Sector (Grade I, 6th practice year)	Wage Gap with Alberta	Wage Gap with Alberta (%)
Speech-Language Pathologist	$44.45	($10.80)	-24.30%
Respiratory Therapist	$38.46	($8.84)	-22.98%
Medical Laboratory Technologist	$38.53	($6.22)	-16.14%
MRI Technologist	$41.50	($6.25)	-15.06%
Anesthesia Assistant	$44.45	($6.19)	-13.93%
Occupational Therapist	$44.68	($4.97)	-11.12%
Physiotherapist	$44.68	($4.97)	-11.12%

We encourage government to consider targeted Labour Market Adjustments for priority professions to ensure BC is competitive and able to attract needed Health Science Professionals.

If our public health care system is to be successful in the ongoing battle against COVID-19 and keeping up with demand for surgeries, diagnostic and rehabilitative services, it will depend on bold and immediate action to address these shortages. HSA is committed to working with government and employers to address the growing professional staffing crisis.

CONCLUSION

Our public health care system is under extreme demand, and the COVID-19 pandemic has put these pressures under a spotlight. Health care professionals are under severe pressure and experiencing mental health issues and burnout at record rates. For Health Science Professionals this current pressure is heightened due to existing shortages in their field.

Investment in Health Science Professionals – not just doctors and nurses – is required.

Jobs in the health science professions are key to our public health care system, but also can play a critical role in our post-pandemic economic recovery. Investing in the health care and social services workforce makes solid economic sense. These are good jobs that support families and communities. And, most importantly, they serve an urgent need in our province.

RECOMMENDATIONS

1. Implement targeted recruitment and retention measures in order to address the public-sector shortage of Health Science Professionals, including more clinical leadership opportunities, increased post-secondary training opportunities, incentives to attract graduates and those in private practice into public practice, and competitive wages with other provinces and the private sector.

2. Increase Ministry of Advanced Education funding to train more Health Science Professionals who face public-sector shortages, including: Physiotherapists, Occupational Therapists, Speech-Language Pathologists, Diagnostic Medical Sonographers, MRI Technologists, Medical Laboratory Technologists, Respiratory Therapists, Anesthesia Assistants, and Perfusionists.

Ministry of Health's Provincial Health Workforce Strategy 2018/19 – 2020/21

Strategic Priority Areas	Priority Professions for 2018/2019	Future Priority Professions
I. Primary Care Services	Nurse Practitioner	Registered Nurse
	Family Physician	Psychologist
	Licensed Practical Nurse (LPN)	Social Worker
	Occupational Therapist (OT)	
	Physiotherapist	
II. Adults with Complex Medical Conditions and /or Frailty	Health Care Assistant (HCA)	Registered Nurse
	Licensed Practical Nurse (LPN)	Rehabilitation Assistant
	Occupational Therapist (OT)	Dietitian
	Physiotherapist	Social Worker
		Medical Specialist
III. Surgical and Diagnostic Services	Nurse (LPN and RN)	Anesthesiologist and GP Anesthesiologist
	Nurse Practitioner	Anesthesia Assistant
	Physiotherapist	Case Manager
	Perfusionist	Surgeon & GP with enhanced surgical skills
		Dietitian
		Counsellor
		Home Nursing Support
		Surgical Services Team
		Clinical Surgical Subspecialists
IV. Mental Health and Substance Use	Psychiatrist	Psychologist
	Registered Psychiatric Nurse	Social Worker
	Occupational Therapist (OT)	Clinical Counsellor
	Family Physician	Trained Peer Support
	Nurse Practitioner	Pharmacist
	Physiotherapist	Dietitian
		Naturopathic Medicine
		Recreation Therapist
		Music and Art Therapists
		Spiritual Services
		Traditional Chinese Medicine and Acupuncturist
		Cross-Cultural Liaison
		Vocational Expert
		Expert in Public Health
		Expert in Psychosocial Rehabilitation

HSA HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

@hsabc
info@hsabc.org
www.hsabc.org

IMPROVE ACCESS TO CRITICAL SERVICES PROVIDED BY CHILD DEVELOPMENT CENTRES

Child Development Centres (CDCs) provide therapy and services to more than 15,000 children and their families throughout the province. CDCs serve children with physical, behavioural, neurological, and developmental disabilities, including cerebral palsy, Down syndrome, autism, fetal alcohol spectrum disorder, and other mental health and behavioural issues.

Funding challenges and shortages of health care and community social services professionals is taking a toll on these critical services that children and their families depend on.

Beyond the clear benefits of health equity and addressing the cognitive, social-emotional, and functional needs of young children, early childhood development makes economic sense. Comprehensive birth-to-age-five early childhood development for vulnerable children provides a return of 13% per year as a result of better outcomes in education, health, sociability, economic productivity, and reduced crime.[1] Put another way, for every dollar invested in comprehensive early childhood development, government receives $6.30 in return in economic, social, and health benefits (referred to as the cost/benefit ratio). The research also indicates a higher return on investment when comprehensive programs begin at birth.

EARLY INTERVENTION THERAPIES PROGRAM NEEDS SIGNIFICANT FUNDING BOOST

Early Intervention Therapies include speech and language therapies to help develop the ability to communicate, physiotherapy to improve mobility and coordination, and occupational therapy to enable children to manage a variety of daily living activities. Early Intervention Therapies also include the use of infant development consultants during the first three years of a child's life. They help parents develop the many skills needed to care for a child with a disability. Child development consultants work with child care centres and preschools so that children with disabilities are able to participate in these programs.

Most Early Intervention funding is provided by the Ministry of Children and Family Development (MCFD) through the Children and Youth with Special Needs (CYSN) funding stream, which includes Early Intervention Therapies, Infant Development, Supported Child Development, and School Age Therapies. A lack of adequate funding for early intervention therapists and a shortage of professionals means that CDCs have long waits for children and families trying to access therapy. In one Northern CDC, for example, there are nearly 250 children on the waitlist trying to access Early Intervention Therapies, and as a result, children are going to school without ever receiving assessments.

Waitlists mean children do not get the care they need when they need it. Failure to do so can result in additional health challenges for children as they attempt to navigate life in the community and at school.

- In the North region, the average wait time for speech services is 335 days.
- In the Vancouver-Coastal region, the average wait for occupational therapy is 180 days.
- In the Fraser region, the average wait time for physiotherapy is 151 days.[2]

---

1 J. Heckman, There's more to gain by taking a comprehensive approach to early childhood development, The Heckman Equation, 2016; World Health Organization & UNICEF, Early Childhood Development and Disability: A discussion paper, 2012.

2 BC Association for Child Development and Intervention, Submission to the Select Standing Committee on Children and Youth, 2019.

As the BC Association for Child Development and Intervention (BCACDI) has reported, the average wait time for speech-language therapy was six months with multiple communities experiencing waits of more than 17 months. Currently there is no systematic and standardized provincial reporting on wait lists, which means wait times vary considerably by community, leading to significant inequities in access to pediatric therapy. BCACDI recommends that MCFD establish a wait-time benchmark of three months. This will require standardized data collection and reporting to inform annual funding increases and resource planning.

In addition to an urgent need to increase funding for Early Intervention Therapies, the government must take action on addressing the severe shortage of professionals providing these services to ensure that children with disabilities will have access to publicly funded care. The supply of qualified and appropriate professionals is outstripped by demand, and is contributing to the long wait lists for service. Increased training for specialized health science professionals is critical to the long-term sustainability of these services.

ADDITIONAL AUTISM SERVICES FUNDING MODEL REQUIRED TO SUPPORT SERVICE DELIVERY BY CDCs

BC relies on the "Individualized Funding" (IF) model which provides direct funding to families/guardians to purchase autism services. While this model may work well for some families, it is increasingly evident that it is not meeting the needs of lower-income and marginalized families. The IF model covers a fraction of the real cost of professional autism services, leaving families and children without financial means without the level of the intensity of services required. Even families with financial means are burdened with unnecessary stress associated with finding appropriate professional autism services in the marketplace. This market-based approach doesn't work in smaller rural and remote communities where there may be few, or no, professionals who can provide these services on a privately-funded basis. Furthermore, this funding model has constrained the ability of non-profit agencies, such as CDCs, to offer sustainable autism programs. Three agency-based autism programs closed in 2019/20 because the funding model does not support the ongoing sustainability of these services provided by appropriate professionals.

We recommend that direct and ongoing funding be provided to Child Development Centres to provide autism services, similar to other program funding for supported child development and early intervention services.

PROVIDE EARLY YEARS MENTAL HEALTH SERVICES FUNDING TO CDCS

In June 2019, the Ministry of Mental Health and Addictions released *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia*. This policy paper committed to "enhance and expand core programming offered in child development centres and by community-based organizations delivering a core set of early intervention services for children under the age of six."[3]

Although CDCs were identified to deliver early years mental health services, in addition to existing core services such as Early Intervention Therapies, it is unclear how this goal is being actioned. CDCs and frontline therapists are eager to provide expanded access to services essential for strong early childhood development, but more resources are needed to increase staffing levels and meet the high demand for service.

3 Ministry of Mental Health and Addictions, *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia* (Victoria: Government of BC, 2019).

BC CHILDREN WITH DISABILITIES NEED MORE SUPPORTED CHILD DEVELOPMENT SERVICES

Children with special needs around the province rely on CDCs for specialized services and supports that enable them to participate in activities that many families take for granted. Supported child development (SCD) assistance provides children with special needs the opportunity to attend child care and preschool programs.

Most SCD funding comes from the Ministry of Children and Family Development (MCFD). Over the last few years funding increases have not kept up with need for CDCs' SCD programs. As a result, wait lists for these services have grown, and too many children with special needs and their families are unable to access child care. Put simply, there are not enough SCD consultants at CDCs for the many children and families who require supports.

The federal and BC governments have made welcome commitments to increase the number of $10/day child care spaces from 6,460 in 2021/22 to 12,500 in 2022/23.[4] As well, by 2022/23, new federal funding is expected to enable approximately 1,190 more children to receive SCD services. We welcome the funding for SCD workforce training and recruitment and retention initiatives earmarked in the new federal-provincial early learning and child care agreement.

In previous years when new child care spaces were created, there has been no increased funding for SCD services provided by CDCs. As a result, children with special needs and their families have not benefitted from these new spaces. The new federal-provincial early learning agreement provides an opportunity to ensure that SCD services are available to all children who need them, and that existing workforce challenges are urgently addressed.

RECOMMENDATIONS

1. Significantly increase funding for MCFD's Early Intervention Therapy Program (speech-language therapy, occupational therapy, and physiotherapy) so that Child Development Centres can ensure timely access to critical services based on a three-month wait-time benchmark.
2. Establish an additional autism services funding model that will enable Child Development Centres to directly provide these services to families.
3. Provide ongoing, appropriate, funding to ensure that children and families in BC can access publicly funded early-years mental health services at their local Child Development Centre.
4. Increase funding for supported child development services delivered by Child Development Centres, so that children with special needs will have equitable access to newly funded child care spaces.

4 Government of Canada & Government of British Columbia, Canada-British Columbia Canada-wide Early Learning and Child Care Agreement, 2021, 7-12.

@hsabc
info@hsabc.org
www.hsabc.org

CHILD DEVELOPMENT CENTRES

Child Development Centres (CDCs) provide services to children with a wide range of physical, neurological, and developmental disabilities (such as cerebral palsy, Down syndrome, autism, and fetal alcohol spectrum disorder), as well as mental health and behavioural issues. Approximately 30 CDCs in British Columbia provide multidisciplinary therapy and integrated services to more than 15,000 children and their families throughout the province.

Health Science Professionals that commonly provide services for children at CDCs include audiologists, behavioural consultants, child and youth mental health counsellors, child life specialists, dietitians, early childhood educators, family support workers, infant development consultants, key workers, occupational therapists, physiotherapists, preschool teachers, psychologists, social workers, speech language pathologists, and supported child development consultants.

CDCs specialize in providing services to children from birth to school entry (usually age 5).

CDC services are essential to enable children with special needs to participate in child care and preschool programs, as well as to make a successful transition into the K-12 school system. Unfortunately, there are too many children that never make it off the wait list before they have aged out of this critical phase of support services, making the transition to school more challenging.

Traditionally, most CDCs have focused on addressing the physical and behavioural needs of children with disabilities, but the need to provide emotional, social and psychological supports for these children and their families is growing.

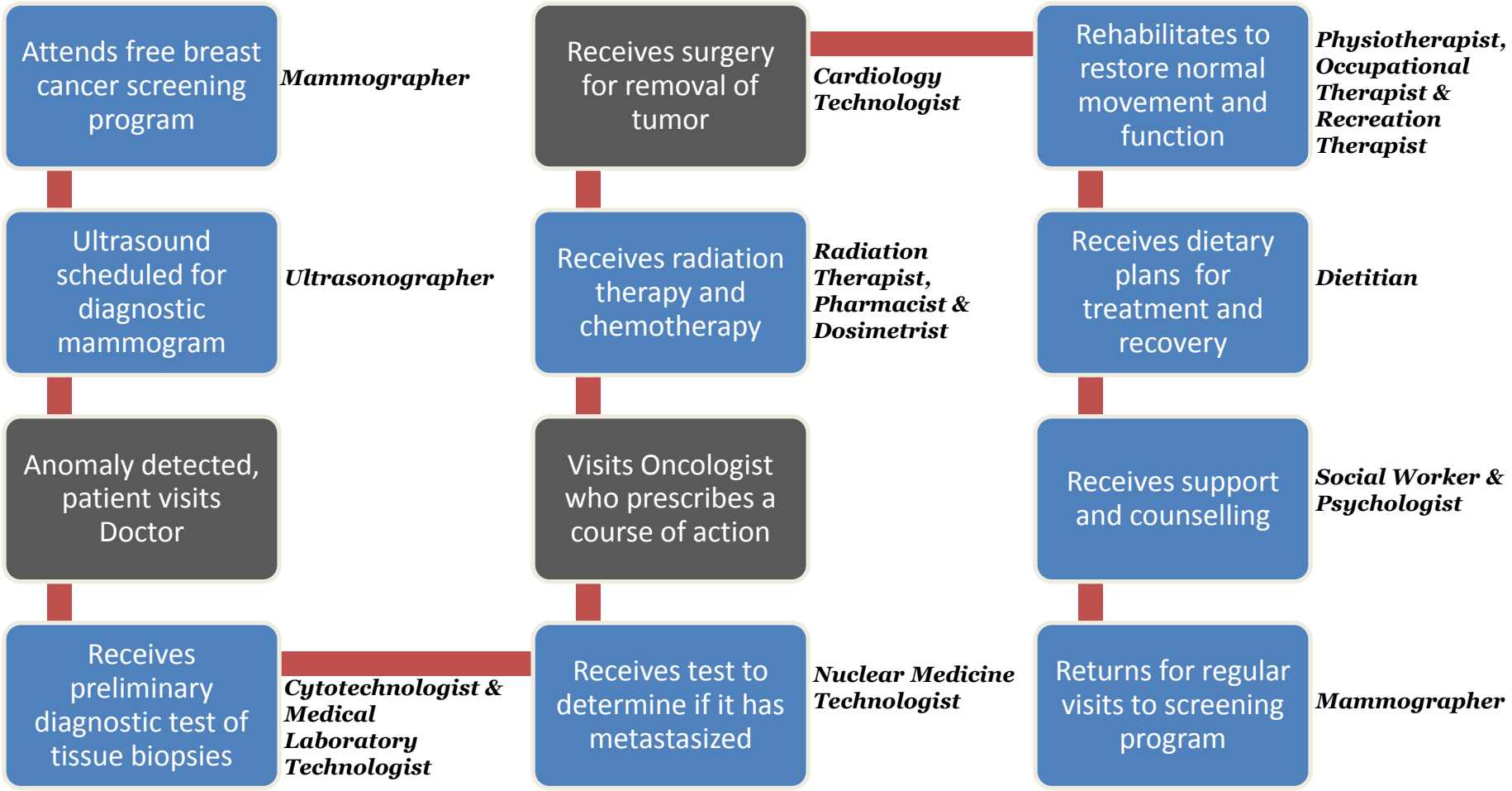
Children with disabilities who do not receive necessary services are less likely to succeed in school, and more likely to require additional ongoing services from MCFD, and the health care and education systems.

Beyond the clear benefits of health equity and addressing the cognitive, social-emotional, and functional needs of young children, early childhood development makes economic sense. Comprehensive birth-to-age-five early childhood development for vulnerable children provides a return of 13% per year as a result of better outcomes in education, health, sociability, economic productivity, and reduced crime.[1] Put another way, for every dollar invested in comprehensive early childhood development, government receives $6.30 in return in economic, social, and health benefits (referred to as the cost/benefit ratio). The research also indicates a higher return on investment when comprehensive programs begin at birth.

1 J. Heckman, There's more to gain by taking a comprehensive approach to early childhood development, The Heckman Equation, 2016; World Health Organization & UNICEF, Early Childhood Development and Disability: A discussion paper, 2012.

HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

Essential to modern health care: Breast cancer example



Submission to the Select Standing Committee on Finance and Government Services

Budget 2022 Consultation

September 2021

HSA

HEALTH SCIENCES ASSOCIATION

The union delivering modern health care

Contents

Message from President Kane Tse

The work of our members is often invisible, but the pandemic continues to demonstrate how critical their contributions are to a functioning health care system.

Respiratory therapists, medical laboratory and imaging technologists, dietitians, pharmacists, physiotherapists, and many others. It's not just doctors and nurses who save lives. It is the whole team of health care professionals.

There is no doubt that COVID-19 has challenged our health care system – it has exposed its strengths and its challenges.

We encourage this Committee to see this moment in time as motivation to commit to deeper investment in our public health care system. We know – and the pandemic has reinforced this – that public health care provides more effective, better quality care than private health care. And we know that our public health care system depends on health care professionals to run it.

This is the moment to ensure our system is as robust as possible – able to recover from this pandemic and build more resilient health and social services.

On behalf of the Health Sciences Association of BC's 20,000 members across the province, I respectfully submit our union's recommendations to the Select Standing Committee on Finance and Government Services for the Budget 2022 Consultation.

Sincerely,

Kane Tse

President, Health Sciences Assocation of BC

Introduction

The Health Sciences Association of BC (HSA) is the union that represents more than 20,000 health science and community social service professionals who deliver specialized services at over 250 hospitals, long-term care homes, child development centres, community health and social service agencies. With members working at every level of health care and social services, in communities all around the province, we have a unique perspective on the delivery and impact of critical services in BC.

HSA was established in 1971 with nine health science professional disciplines at two Lower Mainland hospitals. Today, HSA members, working in over 70 disciplines, provide critical health care and social services that support the health and well-being of British Columbians.[1] HSA is also the lead union in the child development sector, representing 1,000 members at more than 15 non-profit agencies across the province.

Our members are dedicated to better access, better outcomes, and more comprehensive, team-based care in an integrated public system that benefits all British Columbians. HSA is a member of the BC Federation of Labour, the National Union of Public and General Employees, and the BC Health Coalition.

HSA appreciates the opportunity to provide recommendations to the Select Standing Committee on Finance and Government Services as part of the Budget 2022 Consultation. We thank the Committee for considering the perspectives of frontline health science and social service professionals who are committed to improving health and social services for everyone.

1 Health science and social service professional disciplines represented by HSA are listed in Appendix A.

Budget 2022: Mounting health system pressures and professional shortages demand immediate solutions

British Columbia faces intersecting health, environmental, and economic crises. COVID-19 created very difficult fiscal and economic challenge. The pandemic has exposed pre-existing vulnerabilities, gaps, and pressures facing public health care and social services.

Fiscal outlook

The First Quarterly Update shows significantly stronger revenues than anticipated in Budget 2021. It projects revenues of $65 billion in 2021/22 – an increase of $6.2 billion from Budget 2021.[2] In 2021 and 2022, GDP is projected to be higher than projected in Budget 2021.[3] BC has the fiscal capacity to both maintain pandemic responses and make new investments in the health and social services workforce.

Budget 2021 was a stay-the-course budget with few new program commitments compared to previous budgets. Allocated expenditures for health authorities has increased by $1.4 billion since Budget 2021, which reflects additional spending related to COVID-19, primary care, surgical and diagnostic strategy, mental health and substance use services, and the Health Career Access Program for care aides.[4]

Budget 2021 allocated $3.25 billion in pandemic and recovery contingencies, including health services spending and social and business supports. This remains unchanged in the First Quarterly Update. However, as reported in the first quarter, only $317 million has been spent. This suggests that BC may close 2021/22 with significant dollars remaining unspent.[5] This continues BC's tradition of conservative budgeting with large contingencies and forecast allowances that go unspent. This practice creates the appearance that BC has less fiscal capacity than it actually does.

No significant new revenue (tax) measures were introduced in Budget 2021 to increase fiscal capacity and address income or wealth inequality in our province, such as adding new tax brackets on high-income earners or capturing greater revenue from real estate transactions or resource royalties.

Debt remains very manageable, even with new borrowing for capital infrastructure. The debt-to-GDP ratio, a key measure used by international credit rating agencies, is forecast to be 20% in 2021/22, and lower than the projected 23% in Budget 2021. Especially in a low-interest rate environment, capital spending makes good economic sense and provides critical investments into the future.

We urge historic investments in in health care and social services. As Jim Stanford, economist and director of the Centre for Future Work, has stated, the COVID-19 economic recovery must necessarily be a public sector-led recovery:

> Think of post-pandemic rebuilding like a modern Marshall Plan (replicating the enormous, government-funded effort to rebuild Western Europe after the Second World War). We'll need a similar commitment to all-round reconstruction. We will need equally massive fiscal injections. And we will need a similar willingness to use tools of direct economic management and regulation – including public service, public ownership and planning – to make it all happen.[6]

The public and non-profit health care and social services sectors are key to strengthening our economy, and these sectors will be critical for both a speedy recovery and meeting the growing pressures on social services and our public health care system. Jobs in the health care and social services sector make up the second-largest share of total provincial jobs (Table 1). Furthermore, this sector makes up the greatest, second-greatest, or third-greatest share of jobs in most of the province's economic regions.

2 Ministry of Finance, First Quarterly Report (Victoria: Government of BC, Sep. 2021), 5.

3 Ministry of Finance, 2021, 6.

4 Ministry of Finance, 11.

5 Ministry of Finance, 10.

6 J. Stanford, We're going to need a Marshall Plan to rebuild after COVID-19, *Policy Options*, April 2, 2020.

Table 1: Share of total employed by industry (goods- and service-producing sectors), BC and economic regions, 2019

	British Columbia	Vancouver Island and Coast	Lower Mainland-Southwest	Thompson-Okanagan	Kootenay	Cariboo	North Coast and Nechako	Northeast
Wholesale and retail trade	15.2%	13.9%	15.3%	17.7%	15.5%	13.6%	11.9%	13.2%
Health care and social assistance	12.2%	15.3%	11.1%	14.8%	12.7%	14.4%	11.2%	9.3%
Construction	9.2%	9.4%	8.9%	10.9%	8.5%	9.3%	9.1%	12.7%
Professional, scientific and technical services	8.7%	7.2%	10.0%	6.3%	7.1%	4.3%	5.4%	4.9%
Accommodation and food services	7.5%	8.2%	7.1%	8.1%	7.8%	6.8%	11.5%	7.3%
Educational services	7.0%	7.5%	7.0%	6.3%	7.2%	6.9%	7.3%	4.7%
Manufacturing	6.5%	4.2%	6.7%	6.2%	8.8%	10.9%	10.3%	5.4%
Finance, insurance, real estate, rental and leasing	6.2%	4.7%	7.3%	4.1%	2.9%	3.5%	-	4.7%
Transportation and warehousing	5.5%	3.6%	6.1%	4.5%	4.3%	5.8%	5.4%	7.8%
Information, culture and recreation	5.1%	4.0%	5.8%	4.5%	3.6%	2.5%	4.4%	-
Other services (except public administration)	4.6%	5.1%	4.7%	3.6%	3.3%	5.5%	3.7%	6.7%
Public administration	4.5%	9.2%	3.7%	3.4%	3.2%	4.8%	4.7%	-
Business, building and other support services	4.4%	4.2%	4.7%	4.1%	2.8%	2.9%	-	-
Forestry, fishing, mining, quarrying, oil and gas	1.7%	1.8%	0.5%	2.9%	10.0%	6.9%	7.5%	12.2%
Agriculture	1.0%	1.4%	0.8%	2.1%	-	-	-	-
Utilities	0.5%	-	0.5%	-	-	-	-	-

Source: Statistics Canada, Table 14-10-0092-01 Employment by industry, annual, provinces and economic regions.

HSA applauds the provincial government's focus in Budget 2021 on maintaining deficit spending in response to the pandemic and the significant social needs facing British Columbians. But we urge the government to be even more ambitious in Budget 2022, and to make further investments at this precarious time.

Budget 2022 is an opportunity to continue to reinvest in BC's public health care system and to build a strong foundation that will improve the health and well-being of all British Columbians in communities across the province.

Reduce transmission of COVID-19 and the burden on health services

The Delta variant has revealed the necessity of both vaccination and public health measures to slow the current fourth wave. Each wave takes a greater toll on health science professionals working on the frontlines of public health care.

Researchers have consistently predicted the risks of exponential growth and the subsequent pressure on hospitals resulting from variants of concern. In late spring, members of the BC COVID-19 Modelling Group warned of the dangers posed by high transmissibility variants, insufficient population immunity, and the removal of public health measures.[7]

Each wave adds workload pressures and psychological stress on an already-stretched workforce. Health science professionals have been on the frontlines of the pandemic for 20 months now. A 2021 survey of HSA members revealed the extent of pandemic burnout:

- 70% reported that their workload has increased.
- 86% reported that the pandemic has had a somewhat or very negative impact on their mental health.

While heavy workload and burnout pre-date the pandemic, these issues are severe. The ability of our health care workforce to provide high-quality care will be challenged the longer that COVID-19 places significant pressure on hospitals.

Until a very high level of population immunity is reached (and even then, some public health measures may still be required), BC should maintain testing, contact tracing, isolation, and masking. In the most recent reporting period, 52% of positive cases were not traced.[8] This is significantly higher than the cumulative share of cases throughout the pandemic that have not been traced (36%). These pandemic management tools – combined with other interventions – can suppress transmission.[9] This will be necessary in order to:

- reduce the severe strain hospitals and the health workforce, especially in hospitals and ICUs;
- reduce mortality, morbidity, and severe outcomes from COVID-19, which disproportionately impact lower-income people;[10] and,
- reduce the public health care costs of hospitalization due to COVID-19 (average of $23,000 per hospital stay and more than $50,000 per ICU stay).[11]

RECOMMENDATIONS

1. Reduce transmission of COVID-19 and the burden on health services, and maintain low levels of transmission through public health measures as required (e.g., indoor masking, test and trace, physical distancing).

7 P. Tupper, Y. Song, N. Mulberry, C. Colijn, Vaccination and reopening in Canada, Mathematics, Genomics and Prediction in Infection and Evolution, Simon Fraser University, April 2021.

8 BC Centre for Disease Control, COVID-19 Situation Report Week 35, 2021.

9 N. Haug, L. Geyrhofer, A. Londei, E. Dervic, A. Desvars-Larrive, V. Loreto, et al., Ranking the effectiveness of worldwide COVID-19 government interventions, *Nature Human Behaviour* 4 (2021): 1303-1312.

10 Canadian Institute for Health Information, COVID-19 hospitalization and emergency department statistics, August 2021.

11 Canadian Institute for Health Information, 2021.

The tipping point: Address the shortage of health science professionals in public health care

British Columbia is struggling with acute public-sector shortages of health science professionals, including, but not limited to, therapists, diagnostic medical sonographers, medical laboratory technologists, and medical imaging technologists. The specific reasons for these shortages vary by profession, but generally arise from recruitment and retention challenges, including lack of provincial post-secondary training capacity, heavy workload and burnout, lower wages compared to other provinces, private-practice opportunities, and lack of public-sector leadership opportunities.[12]

The health care system has managed under these shortages for many years, but the situation has reached a tipping point and needs immediate attention:

- COVID-19 testing in BC is limited by the severe shortage of Medical Laboratory Technologists.
- Remaining health science professionals are burning out due to workload and excessive overtime demands, accelerating the shortage problem.
- Shortages of respiratory therapists constrain hospital capacity for COVID-19 and other critical care patients.
- Other provinces are attracting BC health science professionals with higher wages and signing bonuses.
- The private sector is luring away physiotherapists and other professionals with higher wages and caseloads that are more manageable.
- Ongoing work to reduce diagnostic and surgical wait times in BC is jeopardized by these shortages.
- Hospital discharges are delayed or patients go without necessary rehabilitation, leading to bed shortages, re-admissions, and widening health inequalities.

The BC Ministry of Health's Provincial Health Workforce Strategy, 2018/19 – 2020/21 indicates that the majority of current and future priority professions with labour market challenges that require provincial attention and monitoring are health science professions (see Appendix B).

The Workforce Strategy points to the many Health Science Professions facing shortages, but from this list there are 14 professions in need of immediate action. These include Medical Laboratory Technologist, Anesthesia Assistant, Medical Resonance Imaging Technologist (MRI), Occupational Therapist, Cardiovascular Perfusionist, Physiotherapist, Respiratory Therapist, Diagnostic Medical Ultrasonographer, Social Worker, Registered Dietitian, Speech Language Pathologist, Clinical Pharmacist, Radiation Therapist, and Radiation Therapy Service Technologist.

41% of HSA members are currently considering leaving public practice due to unmanageable workload.

Many British Columbians have never heard of these professions, nor could they describe the critical role they play in our public health care system. Despite this lack of public awareness, health care would not function without these professionals. It is not just doctors and nurses who save lives and care for British Columbians, but the whole team of health care professionals.

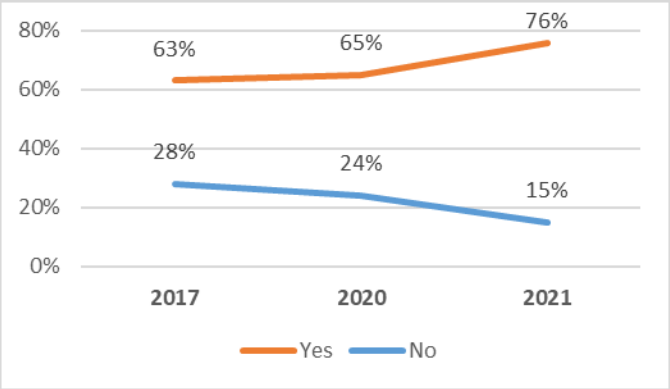
Because of unfilled vacancies and low staffing levels, many departments rely on overtime and casual staffing to deliver necessary services. One hospital department, for example, can only manage demand using upwards of 1,800 to 2,000 hours of overtime each month – and yet they have vacancies that have remained unfilled for a year. This is not a sustainable strategy in the immediate, medium, or long term – either economically or in terms of human resources.

Based on available health authority data, unfilled vacancies for occupational therapists and physiotherapists each increased by roughly 125% between 2014 and 2019.

12 Health Sciences Association of BC, *Achieving High-Performing Primary and Community Care: The Critical Role of the Health Science Professions*, 2018.

The current shortages in these fields are taking a toll. In a 2021 survey of our members, 57% said their department already has a patient waitlist and, for two years in a row, over 40% told us they are considering leaving public practice due to unmanageable workload. Most concerning, 76% reported shortages in their profession, up from 63% in 2017 (Figure 1). Professional shortages have reached a breaking point.

Figure 1: Is your department currently experiencing shortages in your profession? (n=2,698)



Source: HSA Member Survey, Viewpoints Research, August 2021

This is not a sustainable strategy in the immediate, medium, or long term – either economically or in terms of human resources. It is expensive and causes burnout of the limited professionals we have.

The Select Standing Committee on Finance and Government Services, Budget 2021 consultation report commented on the challenge facing our health care system stemming from the shortage of professionals. Recommendation 72 from their report states: *"Provide targeted, increased funding for training health care professionals in areas facing shortages with a focus on expanding capacity and resources within existing programs in smaller communities and ensuring opportunities for British Columbians in rural, remote and Indigenous communities to train locally."*

Some progress, but more government action is required

In 2019, the BC government took positive steps towards addressing health science rofessional shortages in the public sector. Forty new first-year physiotherapy and 24 occupational therapy training seats will open between 2020 and 2022 across the province.[13] A new diagnostic medical sonography training program opened in early 2019 at College of New Caledonia in Prince George, and a new program at Camosun College on Vancouver Island will be fully operational by 2021.[14] These two new programs build the province's training capacity by adding to the approximately 40 students trained at BCIT.

Budget 2021 provides $96 million in new funding over three years to support expansion of post-secondary training capacity for nurses and health science professionals. Although details of the post-secondary seat expansion are not yet available, without significant commitment to expansion of training for health science professions, no headway will be made in the medium and long term on addressing the shortages.

In addition, the BC government continues to build its workforce planning expertise through the creation of the new Allied Health Policy Secretariat in the Ministry of Health, which recently completed the first-ever survey of allied health workforce. We applaud the Ministry for engaging frontline professionals about severe shortages, heavy workload, and lack of career advancement and leadership opportunities.

These are important steps, and we need to continue to invest in post-secondary training opportunities and capacity in the other professions facing severe shortages.

However, increased training alone will not be enough. We must be thinking about innovative incentives to bring new

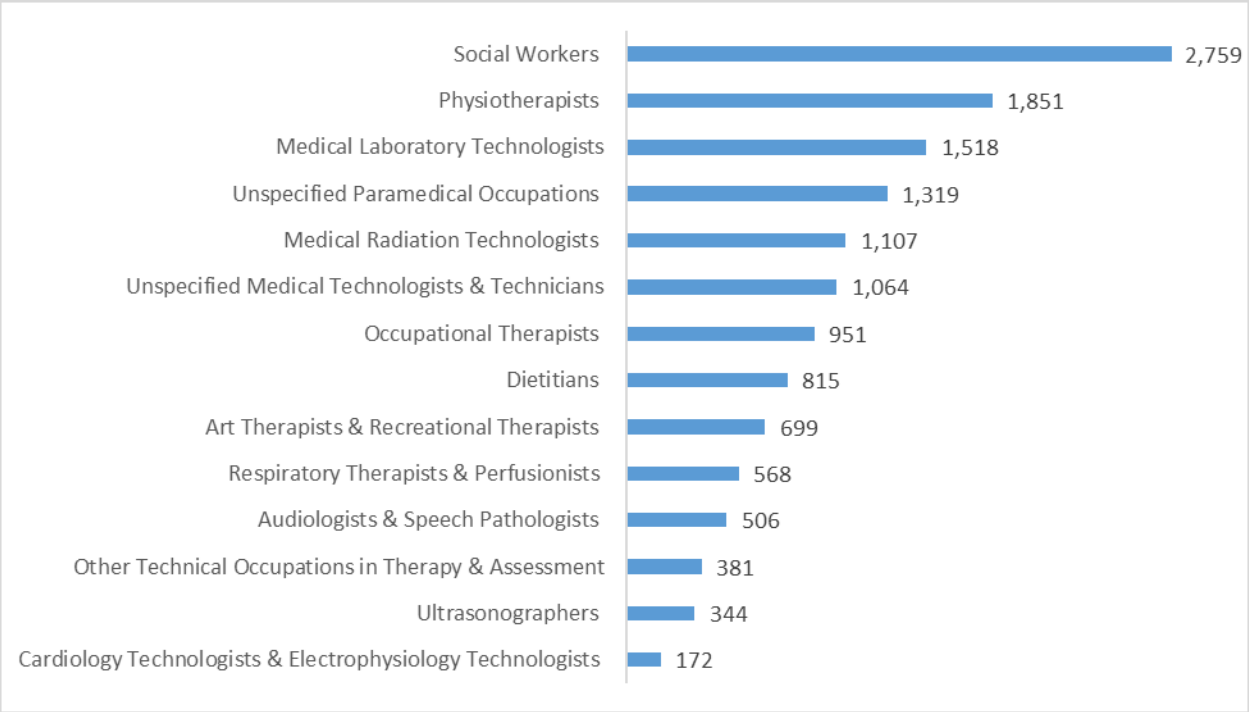
13 Ministry of Advanced Education, Skills and Training, Occupational and physical therapy seats coming to Northern BC, May 24, 2019. There are currently 80 first-year physiotherapy seats in BC. This will increase to 120 first-year spaces, with full expansion expected by September 2022. The First 20 seats will be at UBC Vancouver, followed by Fraser Valley. The most recent increase was in 2008. In occupational therapy, there are 48 first-year seats in BC. This will increase to 72 first-year seats with the first eight at UBC Vancouver (Sep. 2020) and 16 through a joint UBC/UNBC initiative (Sep. 2022). The most-recent increase was in 2009.

14 Ministry of Advanced Education, Skills and Training, Northern B.C.'s First Sonography Program Gets Underway, Jan. 28, 2019; Ministry of Advanced Education, Skills and Training, First sonography program coming to Vancouver Island, October 17, 2019.

graduates into public health care, and strategies to maintain and increase existing staffing levels.

Many Health Science Professions are designated WorkBC High Opportunity Occupations, with thousands of job openings to be filled by 2029 (Figure 2). The vacancies are likely to increase as demand for health care increases as a result of COVID-19.

Figure 2: WorkBC job openings, 2019 to 2029



One of the most profound challenges is that many Health Science Professionals can earn more and carry lighter workloads in the private sector.

HSA has worked to address the professional shortages crisis through negotiated collective bargaining. In addition to general wage increases, HSA successfully negotiated the Recruitment and Retention Working Group that includes the bargaining association (union), employer, and government representatives. The purview of the Working Group was to jointly develop targeted recruitment and retention strategies that would help address public sector health science professional shortages.

The Working Group developed a comprehensive set of broad-based and profession-specific recommendations, including increased staffing levels as a pre-condition to deal with severe workload issues that drive professionals out of the public sector, more leadership and practice support positions, enhanced provincial recruitment supports for shortage professions, profession cross-training, changes to credentialing requirements to fast-track students into positions, and temporary market (wage) adjustments.

Unfortunately, employer and government representatives were unwilling to agree to jointly-developed strategies in summer 2020, including labour market (wage) adjustments needed to make a number of health science professions competitive with other provinces and the private sector. In fact, as HSA research shows, many Ministry-designated priority professions have significant wage gaps with Alberta (Table 2). This – combined with BC's high cost of living – puts BC's public health care system at a competitive disadvantage when it comes to recruiting and retaining health science professionals.

Table 2: Selected BC health science professions by wage gap with Alberta

	BC Public Sector (Grade I, 6th practice year)	Wage Gap with Alberta	Wage Gap with Alberta (%)
Speech-Language Pathologist	$44.45	($10.80)	-24.30%
Respiratory Therapist	$38.46	($8.84)	-22.98%
Medical Laboratory Technologist	$38.53	($6.22)	-16.14%
MRI Technologist	$41.50	($6.25)	-15.06%
Anesthesia Assistant	$44.45	($6.19)	-13.93%
Occupational Therapist	$44.68	($4.97)	-11.12%
Physiotherapist	$44.68	($4.97)	-11.12%

If our public health care system is to be successful in the ongoing battle against COVID-19 and keeping up with demand for surgeries, and diagnostic and rehabilitative services, it will depend on bold and immediate action to address these shortages. HSA is committed to working with government and employers to address the growing professional staffing crisis.

Health science professionals on the staffing crisis

I hear a lot of platitudes about resilience in my line of work, however the term that comes to my mind is compensation. In the lab, compensation is a biochemical term. We use it to describe events such as your kidneys' ability to maintain your body's pH, despite your electrolytes being out of balance, or your body's ability to tolerate an alarmingly low level of haemoglobin when the decrease has been gradual over time. It's why, for example, you fainted while making dinner, you are suddenly now in emergency, and the doctor is ordering labs. You may never meet your lab team, but we are quite concerned about you. Some of the numbers we are seeing in your bloodwork are ominously low, and are inconsistent with your bright demeanour while you were chatting with the phlebotomist. Our medical team will help you, and quickly, whether you need to get your blood sugar sorted out, or to get a transfusion, but we also know that you could not have gone on much longer like this. Your body is very good at pressing on until it can't, and we are very good at making sure that you get thorough, accurate, and expedient diagnostics.

Until we can't.

This was never about resilience at all, but simply about eventuality: the thing that happens when we can no longer compensate. The staffing shortages of medical professionals have made you wait a little longer for a test result, and have caused physical and moral injuries to us. We are exhausted. We have depleted our last-resort buffering abilities.

The shortages of allied health professionals are at levels now that they have shut down entire emergency departments. My colleagues and I have been brought to tears when we physically cannot get those stat results out any faster, knowing the desperation of those waiting for them. We are working at a pace that has us terrified that we might make a mistake. It's beyond time that we stop discussing hospital capacity by the number of beds, or even the number of doctors and nurses. Each bed represents a myriad of professions who depend on each other to the extent that if any member of that team can no longer provide care, that bed is as good as not there.

Let's stop talking about resilience. We will all run ourselves into the ground for sake of our patients, and our whole system has banked on our willingness to do so. We've done that. We're there. We're buried. We can no longer compensate without adequate resources.

–Medical Laboratory Technologist, Vancouver Island Health

Fifteen years ago when I started as a Social Worker in Vancouver, getting a permanent position was something people waited years for. Now, in 2021, we can barely keep staff in positions. There are many vacant permanent positions, putting further strain on overworked, burned-out staff. When one position is vacant, we are asked to cover multiple roles and multiple units. There is an expectation that social workers assist with hospital discharges, domestic violence assessments, housing, addictions counseling, trauma counseling, grief counseling, financial counseling, disability applications and so on. When I go see my social work site leaders, they are so stressed and overworked that they barely have time to talk to me.

Amongst my social work colleagues, we have lost eight staff to non-acute care roles in the last year. Many staff are

choosing to go to casual positions because they cannot handle the stress of their permanent positions. Nine other social work colleagues have left in the last few years for more affordable housing outside of the Lower Mainland.

It is a horrible feeling to go home at the end of your work day and feel like you neglected your responsibilities because you just did not have time or energy to help each and every person that needed you.

Added to the day-to-day strain of working with marginalized, traumatized, ill people is the toll of the opioid crisis and the global pandemic. More and more of my patients are dying of overdoses because the COVID border closures have meant the current drug supply is tainted by local producers. Every week I arrive to work fearing news of which patient died of an overdose over the weekend.

There are not enough community resources to support the complex folks coming in and out of the acute care. We are failing the very people we set out to help.

Some things cannot be changed, but the quality of life of a social worker can potentially be improved by:

- Offering part time positions for young parents or people looking for more flexibility.
- Offer incentives to people who have difficulty affording to live in Vancouver on the hourly rate many allied health staff are paid.
- Offer more opportunities for employer paid education to recognize the importance of professional development.
- Offer greater support for staff experiencing burnout or compassion fatigue.
- Figure out how to address the increase in violence directed towards staff.
- Provide more educator positions to support new staff.
- Provide more leadership opportunities to foster those skills for staff who are interested.
- Provide better addictions treatment options and housing resources so we do not need to continue disappointing the people we serve.

Without intervention, the province risks a vicious cycle where fewer and fewer workers are handling more and more work until burnout destroys the sector.

–Social Worker, Vancouver Coastal Health

I am a dietitian by schooling but chose to become a respiratory therapist after witnessing the amazing things they do to provide care for all those in need. Respiratory therapists are one of only a few professions that go directly into critical care after their training. Needless to say, this pandemic, being respiratory in nature, has put us right in the line of fire. Unfortunately, this pandemic has left us with a climate of high medical demand with low supply of health care professionals.

In the past year I've witnessed seemingly countless hours of overtime, unfilled vacancies and practices being amended due to balancing the health care needs of our patients with the amount of health care professionals available to provide that care.

I love being a respiratory therapist; however, this feeling is challenged every day I walk into the hospital knowing that I'm going to be greeted with this supply/demand problem. The feeling of "burnout" accompanied by working short can sometimes be mitigated by calling in sick. This in turn becomes a vicious cycle that compounds the culture of working short.

Safety and patient care is my primary concern. However, it can be difficult to provide a quality of care our patients deserve when there are not enough respiratory therapists to support each other.

–Respiratory Therapist, Interior Health

Responding to COVID-19 and reducing wait times for surgery and diagnostic testing

The ongoing COVID-19 pandemic continues to put pressure on hospital capacity, making it difficult to catch up and keep up with scheduled surgeries and diagnostic testing. As the BC government maintains high levels of surgical and diagnostic testing volumes, it is critical that we have the health science professionals in place, and that we are not relying on overtime and casual work to meet the demand.

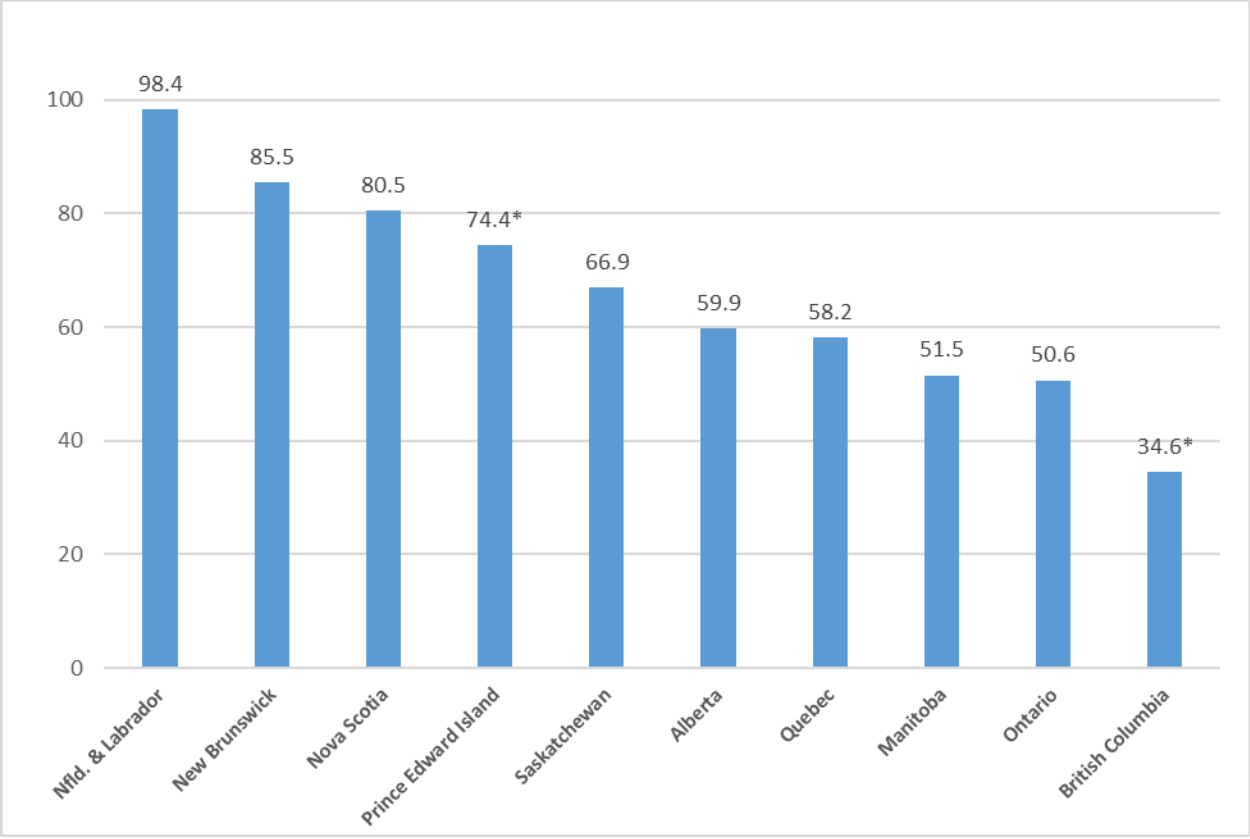
The BC government is on the right track increasing hospital hours to perform more surgeries and diagnostic testing, but as the evidence indicates, it must be accompanied by system improvements. Increasing surgical volumes, without addressing the inefficiencies of current processes (e.g., managing waitlists, referral processes, team-based care pathways), risks workforce burnout and delaying working down the surgical backlog. The COVID-19 backlog demands bold steps to make team-based pre-surgical, perioperative, and post-surgery system improvements standard practice provincially.[15] These public innovations, including administrative efficiencies by moving waitlists from individual surgeons' offices to centralized health authority waitlists, reduce public wait times.

It is critically important that BC have the highly trained laboratory workforce now and in the future required to test for COVID-19 and emerging infectious diseases. Medical laboratory technologists are skilled professionals necessary for delivering COVID-19 test results. Due to low staffing levels and recruitment and retention challenges, BC has the lowest number of medical laboratory technologists per capita among the provinces. In 2019, BC had 35 Medical Laboratory Technologists per 100,000 people, significantly below all the provinces and the second-lowest, Ontario with 51 per 100,000 people (Figure 3).

Furthermore, BC faces a shortage of respiratory therapists who are essential to caring patients with COVID-19 and other cardio-respiratory conditions. Respiratory therapists are specialized professionals who work with ICU teams to intubate patients, and they also play a vital role in hospital and outpatient settings in the areas of ventilator management, non-invasive ventilation therapies, respiratory assessments, management of patient oxygen needs, airway management, and patient education and self-management supports following discharge.

Alarmingly, BC has the fewest respiratory therapists per capita among the provinces (Figure 4). In fact, the number of respiratory therapists per capita declined between 2015 and 2019. BC was one of only two provinces to experience a decline.

Figure 3: Medical laboratory technologists per 100,000 population, 2019



Source: Health Workforce Database, Canadian Institute for Health Information; Statistics Canada, Demography Division.
*Counts may be understated due to the non-regulatory status of the profession as of 2019. Please use with caution.

15 A. Longhurst, M. Cohen, & M. McGregor, *Reducing Surgical Wait Times: The Case for Public Innovation and Provincial Leadership* (Canadian Centre for Policy Alternatives, 2016); D. Urbach & D. Martin, Confronting the COVID-19 surgery crisis: Time for transformational change, *CMAJ* 192, no. 21 (2021): E585-6.

Figure 4: Respiratory therapists per 100,000 population, 2015 to 2019

	2015		2019		2019 rank per 100k	Change in RTs per 100k, 2015 to 2019
	Count	Number per 100,000	Count	Number per 100,000		
NB	369	48.6	429	55.7	1	14%
QC	4,143	50.7	4,404	52.5	2	4%
AB	1,677	40.5	1,895	44.0	3	9%
NS	289	30.9	346	36.0	4	17%
NL	141	26.7	162	30.8	5	15%
MB	328	25.0	331	24.5	6	-2%
ON	3,152	23.0	3,446	24.1	7	5%
SK	223	19.9	256	22.0	8	11%
PEI	25*	17.3*	31*	20.2*	9	17%
BC	950*	19.9*	979*	19.6*	10	-1%

Source: Canadian Institute for Health Information (2020), Canada's Health Care Providers, 2015 to 2019 (data tables).

Note: 2015 data for MB are unavailable and 2016 data have been used instead.

* Counts may be understated due to the non-regulatory status of the profession as of 2019. Use with caution.

Conclusion

Our public health care system is under extreme pressure, and the COVID-19 pandemic has brought these pressures under a spotlight. Health care professionals are under severe pressure and experiencing mental health issues and burnout at record rates. For health science professionals, this current pressure is heightened due to existing shortages in their field.

Investment in health science professionals – not just doctors and nurses – is required.

Jobs in the health science professions are key to our public health care system, but also can play a critical role in our post-pandemic economic recovery. Investing in the health care and social services workforce makes solid economic sense. These are good jobs that support families and communities. And, most importantly, they serve an urgent need in our province.

RECOMMENDATIONS

2. Implement targeted recruitment and retention measures in order to address the public-sector shortage of health science professionals, including more clinical leadership opportunities, increased post-secondary training opportunities, incentives to attract graduates and those in private practice into public practice, and competitive wages with other provinces and the private sector.

3. Maximize and optimize public-sector surgical and diagnostic testing capacity rather than contracting out publicly-funded procedures to for-profit facilities, and implement evidence-based public innovations that reduce wait times.

4. Increase Ministry of Advanced Education funding to train more health science professionals who face public-sector shortages, including: physiotherapists, occupational therapists, speech-language pathologists, diagnostic medical sonographers, MRI technologists, medical laboratory technologists, respiratory therapists, anesthesia assistants, and perfusionists.

Improve occupational health and safety for health science and social service professionals

The COVID-19 pandemic has clearly demonstrated the considerable risks that health care and social service workers face day after day, and not only to their physical health but their mental wellness. The realities of working during a pandemic highlight the need to improve occupational health and safety.

Ongoing health care outbreaks underscore importance of personal protective equipment

WorkSafeBC claims data provide a snapshot of the effects of COVID-19 on frontline staff. Since the beginning of the pandemic until August 31, there were 4,046 claims—the majority (2,186 or 54%) from health care and social services sectors.[16]

Moreover, COVID-19 cases in health care workers remain too high. Between the end of the second wave (February 2021) and the end of the third wave, nearly 2,200 additional health care workers were infected with COVID-19.[17] And while more recent data are not available, we are seeing a growth in health care facility outbreaks in the fourth wave. As of September 21, there were 22 active outbreaks across three hospitals and 19 seniors' care settings. Workers continue to be infected.

HSA has been at the forefront of improving occupational health and safety amidst the pandemic. In October 2020, HSA commissioned University of Toronto occupational hygienist Dr. John Murphy to review the scientific literature on aerosol transmission and personal protective equipment. Following this review, HSA called on government and employers to ensure that workers had access to the highest level of personal protective equipment, including N95 respirators, necessary to prevent infection from an airborne pathogen.[18] Following HSA's advocacy, the Ministry of Health granted workers access to N95 respirators following a point-of-care risk assessment. HSA wanted to ensure that workers would have unrestricted access to the appropriate level of protection based on an individualized assessment of COVID-19 exposure risk.

Today, the increased transmissibility of the Delta variant and the continuing outbreaks underscore the importance of frontline workers' unrestricted access to the highest level of PPE, including respirators, upon their risk assessment. There is no longer a national or provincial shortage of N95 respirators. Still, PPE access remains an issue for some members, and we urge government and health authorities to ensure that the provincial policy is implemented consistently across health authorities and workplaces. We also urge government to ensure that health and community social services sector employers uphold legal and collective agreement obligations regarding the role of Joint Occupational Health and Safety committees.

Expand mental health presumptive coverage to all health care and community social service professionals

Health care and community social service professionals are on the front lines of support, often in very challenging situations. On any day, these workers may face a traumatic event on the job that can result in a mental health injury. However, they face barriers to quickly accessing the support they need to recover.

In 2019, presumptive coverage was extended to emergency dispatchers, nurses, and care aides to ensure they have easier access to workers' compensation for psychological injuries and work-related trauma. This was a very positive step by the BC government, however it does not extend coverage to the whole team of health care and social service professionals who face psychological injuries and trauma.

We urge the BC government to expand WorkSafeBC presumptive coverage to all health care and community social service professionals. When a worker receives a formal diagnosis of PTSD or another mental health disorder as a result of a work-related traumatic event, presumptive coverage makes it easier to advance a worker's compensation claim. We know that the faster someone receives support, the faster their recovery. It also means they can return to work faster. COVID-19 makes the urgency of presumptive coverage for the whole health care and social services team even more

16 WorkSafeBC, COVID-19 claims data (claims as of Aug. 31, 2021).

17 Calculated by subtracting figures in Table 1 in the following two BC Centre for Disease Control reports: COVID-19 cases in healthcare workers: Jan 1, 2020 – Feb 19 & COVID-19 cases in healthcare workers: Jan 1, 2020 – June 18, 2021.

18 HSABC, HSA renews calls for enhanced PPE for workers in vulnerable settings, October 7, 2021. For a review of the most recent scientific consensus on the airborne transmission of COVID-19, see T. Greenhalgh et al., Ten scientific reasons in support of airborne transmission of SARS-CoV-2, *The Lancet* 397, no. 10285 (2021).

urgent.

RECOMMENDATIONS

5. Ensure all health care workers, including health science professionals, have ready and unhindered access personal protective equipment, including N95 respirators.

6. Expand presumptive coverage to include all health care and community social service professionals under the Workers Compensation Act Mental Disorder Presumption Regulation.

7. Provide regular public reporting of COVID-19 cases among workers in health care and community social services by occupational classification.

Rebuild public rehabilitative care in BC

A forthcoming HSA report examines the state of public rehabilitation services for patients requiring therapy from debilitating illness, chronic disease, injury or recovering from surgery.

Rehabilitative care includes physiotherapy for strength and to enable movement, occupational therapy for the skills necessary for everyday living, and speech and language therapy for communication and swallowing. Rehabilitative care provides essential therapies to foster wellness, quality of life, and optimize and maintain functional abilities. Rehab professionals provide care across the health care system for people of all ages, including children, seniors, and people with chronic disease or disability.

However, the erosion and privatization of these specialized services over two decades has led to staffing shortages, a lack of services in many communities, and long wait times for patients and clients, including children and their families. Drawing research literature, statistical data from health authorities and the Canadian Institute for Health Information as well interviews and focus groups with HSA members, the report found that:

- Public rehabilitation funding is falling short. Between 2005/05 and 2018/19, public funding for hospital diagnostic and therapeutic services in BC declined from $232 to $217 per capita (inflation-adjusted).[19]
- Access to public rehabilitative care is stagnant or declining in most regions when looking at public sector physiotherapist, occupational therapist, and speech-language pathologist staffing (measured as full-time equivalent) per population. For example, BC lost 89 public sector physiotherapists between 2010 and 2019. On a per capita basis, the number of physiotherapists in the public sector declined from 31 to 25 per 100,000 between 2010 and 2019.[20]
- Therapy shortages undermine quality of care and lead to long wait times and increased length of hospital stay when patients cannot be discharged due to a lack of staffing.
- Shortages cause burnout and impede recruitment and retention.
- Chronic unfilled vacancies are widespread and are sometimes used to justify funding cuts to therapy departments.
- Therapists have limited or no opportunities for clinical leadership and career advancement in the public sector.
- The erosion and privatization of public rehabilitative care and outpatient closures is the result of inadequate funding and staffing levels as demand for services grow. In addition, the lack of a provincial approach to rehabilitative care means that outpatient rehab is limited or non-existent in most communities.

RECOMMENDATION

8. The Ministry of Health, health authorities, and Ministry of Children and Family Development should develop a provincial plan to rebuild public rehabilitative services in the province, starting immediately with expanding inpatient and outpatient services at hospitals and Child Development Centres by filling vacancies and increasing baseline staffing.

19 Canadian Institute for Health Information, Trends in Hospital Expenditure, 2005-2006 to 2018-19: Data Tables (Series B: Hospital Expenditures by Functional Area), 2020; BC Stats population estimates.

20 Canadian Institute for Health Information, Physiotherapists in Canada, 2019 — Data Tables, 2020; BC Stats population estimates.

Improve access to early intervention therapy, autism services, and early-years mental health supports in Child Development Centres

Child Development Centres (CDCs) provide therapy and services to more than 15,000 children and youth and their families. CDCs serve children with physical, behavioural, neurological and developmental disabilities, including cerebral palsy, Down syndrome, autism, fetal alcohol spectrum disorder, and other mental health and behavioural issues. CDCs provide Early intervention therapies for children with disabilities from birth to age five, enabling these children to participate in school and in their communities.

Early Intervention Therapies program needs significant funding boost

Early Intervention Therapies include speech and language therapies to help develop the ability to communicate, physiotherapy to improve mobility and coordination, and occupational therapy to enable children to manage a variety of daily living activities. Early Intervention Therapies also include the use of infant development consultants during the first three years of a child's life - they help parents develop the many skills needed to care for a child with a disability. Child development consultants work with child care centres and preschools so that children with disabilities are able to participate in these programs.

Most early intervention funding is provided by the Ministry of Children and Family Development (MCFD) through the Children and Youth with Special Needs (CYSN) funding stream, which includes Early Intervention Therapies, Infant Development, Supported Child Development and School Age Therapies. A lack of funding for early intervention therapists means that CDCs have long waits for children and families trying to access therapy. In one Northern CDC, for example, there are nearly 250 children on the waitlist trying to access Early Intervention Therapies, and as a result, children are going to school without ever receiving assessments.

As the BC Association for Child Development and Intervention (BCACDI) has noted, from 2008 to 2016, there were no increases in the Early Intervention Therapies budget provincially. In 2016, the program saw a small increase. And although budget consultation reports in 2018, 2019, and 2020 each made specific recommendations to increase investment in early intervention services, increased funding was not provided. As a result, Early Intervention Therapies continue to have the longest wait times province-wide.

Today, the Early Intervention Therapies program still has the longest waits among CDC programs as funding remains insufficient. As BCACDI has reported, average wait times for speech-language therapy was six months with multiple communities experiencing waits of more than 17 months. BCACDI recommends that MCFD establish a wait-time benchmark of three months. This will require standardized data collection and reporting to inform annual funding increases and resource planning. Currently there is no systematic and standardized provincial reporting which means wait times vary considerably by community and lead to significant inequities in access to pediatric therapy.

Waitlists mean children do not get the care they need when they need it. For example, clinical guidelines for children document the essential need for early interventions by rehabilitation professionals. Failure to do so can result in additional health challenges for children as they attempt to navigate life in the community and at school.

- In the North region, the average wait time for speech services is 335 days.
- In the Vancouver-Coastal region, the average wait for occupational therapy is 180 days.
- In the Fraser region, the average wait time for physiotherapy is 151 days.[21]

There is an urgent need to increase funding to CDCs, especially for early intervention therapies. There are simply not enough clinicians to ensure that children with disabilities will have access to publicly funded services.

Beyond the clear benefits of health equity and addressing the cognitive, social-emotional, and functional needs of young children, early childhood development makes economic sense. Comprehensive birth-to-age-five early childhood development for vulnerable children provides a return of 13% per year as a result of better outcomes in education, health, sociability, economic productivity, and reduced crime.[22] Put another way, for every dollar invested in comprehensive early childhood development programming, government receives $6.30 in return in economic, social,

21 BC Association for Child Development and Intervention, Submission to the Select Standing Committee on Children and Youth, 2019.

22 J. Heckman, There's more to gain by taking a comprehensive approach to early childhood development, The Heckman Equation, 2016; World Health Organization & UNICEF, Early Childhood Development and Disability: A discussion paper, 2012.

and health benefits (referred to as the cost/benefit ratio). The research also indicates a higher return on investment when comprehensive programs begin at birth.

Additional autism services funding model required to support service delivery by CDCs

BC relies on the "Individualized Funding" (IF) model which provides direct funding to families/guardians to purchase autism services. While this model may work well for some families, it is increasingly evident that it is not meeting the needs or lower-income and marginalized families. It burdens families with unnecessary stress to find professional autism services in the marketplace that are appropriate and affordable. The IF model covers a fraction of the real cost of professional autism services, leaving families and children without the intensity of service that is required.

Furthermore, this market-based approach has limited efficacy in smaller rural and remote communities where there may be few, or no, professionals who can provide these services on a privately-funded basis. Furthermore, this funding model has constrained the ability of non-profit agencies, such as CDCs, to offer sustainable autism programs. Three agency-based autism programs closed in 2019/20 because the funding model does not support the ongoing sustainability of these services provided by appropriate professionals.

We recommend that direct and ongoing funding be provided to Child Development Centres to provide autism services, similar to other program funding for supported child development and early intervention services.

Provide early years mental health services funding to CDCs

In June 2019, the Ministry of Mental Health and Addictions released *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia*. This policy paper committed to "enhance and expand core programming offered in child development centres and by community-based organizations delivering a core set of early intervention services for children under the age of six."[23]

Although CDCs were identified to deliver early years mental health services, in addition to existing core services such as Early Intervention Therapies, it is unclear how this goal is being actioned. CDCs and frontline therapists are eager to provide expanded access to services essential for strong early childhood development, but more resources are needed to increase staffing levels and meet the high demand for service.

BC children with disabilities need more supported child development services and pediatric therapy

Children with special needs around the province rely on CDCs for specialized services and supports that enable them to participate in activities that many families take for granted. Supported child development (SCD) assistance provides children with special needs the opportunity to attend child care and preschool programs.

Most SCD funding comes from the Ministry of Children and Family Development (MCFD). Over the last few years there have been insufficient funding increases to CDCs' SCD programs. In other cases, base contract funding for SCD has increased in communities that do not face the greatest access challenges. Moving forward, new investments need to be informed by data and evidence. We echo organizations including BC Centre for Child Development and Intervention that been advocating for much greater system-level data collection and reporting to inform funding increases.

As a result, wait lists for these services have grown, and too many children with special needs and their families are unable to access child care. Put simply, there are not enough SCD consultants at CDCs for the many children and families who require supports.

The federal and BC governments have made welcome commitments to increase the number of $10/day child care spaces from 6,460 in 2021/22 to 12,500 in 2022/23.[24] As well, by 2022/23, new federal funding is expected to enable approximately 1,190 more children to receive SCD services. We welcome the funding for SCD workforce training and recruitment and retention initiatives earmarked in the new federal-provincial early learning and child care agreement.

In previous years when new child care spaces were created, there has been no increased funding for SCD services provided by CDCs. As a result, children with special needs and their families have not benefitted from these new spaces. The new federal-provincial early learning agreement provides an opportunity to ensure that SCD services are available to all children who need them, and that existing workforce challenges are urgently addressed.

---

23 Ministry of Mental Health and Addictions, *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia* (Victoria: Government of BC, 2019).

24 Government of Canada & Government of British Columbia, Canada-British Columbia Canada-wide Early Learning and Child Care Agreement, 2021, 7-12.

RECOMMENDATIONS

9. Significantly increase funding for MCFD's Early Intervention Therapy Program (speech-language therapy, occupational therapy and physiotherapy) so that Child Development Centres can ensure timely access to critical services based on three-month wait-time benchmark.

10. Establish an additional autism services funding model that will enable Child Development Centres to directly provide these services to families.

11. Provide ongoing, appropriate, funding to ensure that children and families in BC can access publicly funded early-years mental health services at their local Child Development Centre.

12. Increase funding for supported child development services delivered by Child Development Centres, so that children with special needs will have equitable access to newly funded child care spaces.

Renew and expand health and social infrastructure

Capital spending on infrastructure in the health sector – including hospitals, long-term care facilities, and new equipment and technology – will total $7.8b over the next three years.[25] Projects include new St. Paul's Hospital, integrated hospital and cancer centre in Surrey, Phase 2 of the Royal Columbian Hospital Redevelopment, replacement of the Cowichan District Hospital, replacement of the Mills Memorial Hospital in Terrace. HSA welcomes these significant investments.

Considering that much of BC's health care facilities were built in the post-war era, it is critical that we see stable increases in capital spending in order to both maintain existing capital infrastructure and service levels and build new facilities to meet the needs of our growing population. As our debt-to-GDP ratio is very manageable, we have the fiscal room to make bold investments in maintaining and expanding our capital infrastructure.

Unfortunately, due to the use of public-private partnerships (P3s) initiated between 2001 and 2016, BC has not received the best value for money compared to traditional capital procurement and financing. A recent evaluation of P3s found that between "2003 to 2016, BC committed $18.2 billion in multi-decade contracts to finance 17 public infrastructure projects through P3s. The cost of the 17 P3s is at least $3.7 billion higher than it would have been if the projects had been carried out through more traditional forms of procurement."[26] P3s inflate costs to taxpayers. Building on the provincial government's current focus on enhancing public services and infrastructure, we urge all future capital infrastructure to be delivered through more cost-effective traditional procurement.

In particular, we urge big capital investments to renew and expand outpatient rehabilitative care spaces, many of which are too small and require updates. The BC government should also rebuild public and non-profit seniors' long-term care. COVID-19 has shone a light on the serious shortcomings of our underfunded, fragmented, and privatized seniors' care system.[27] A significant share of BC's health authority and non-profit-owned care homes are older and will require replacement. We know from a large body of empirical health services research that staffing levels and mix are key predictors of care quality and resident health outcomes. Canadian and international research demonstrates that health authority and non-profit-owned care homes provide generally superior care compared to care provided in facilities owned by for-profit companies.[28]

Underfunding, privatization, and contracting out have fragmented and undermined the critical work of all members of the care team, including health science professionals. The single-site order has revealed low overall staffing levels in seniors' care, with the greatest concerns in the for-profit sector. COVID-19 has also revealed the significant number of health science professionals, including physiotherapists, speech-language pathologists, occupational therapists, social workers, respiratory therapists, recreation therapists, dietitians, clinical pharmacists, among others, who must travel to multiple sites and have very limited time with each resident because of insufficient funding for specialized care provided by these professionals.

COVID-19 tells us that we can no longer ignore the crisis in seniors' care. We applaud the BC government's significant commitment to increasing staffing levels in long-term care. However, we believe now is the time for the BC government to develop a capital plan to increase access to publicly funded seniors' care operated by health authorities and non-profit organizations.

RECOMMENDATIONS

13. Make bold investments in maintaining and expanding our health and social infrastructure, including outpatient rehabilitative care and public and non-profit long-term care with increased staffing levels of health science professionals.

14. Develop a provincial capital plan to guide investments in renewed and expanded health infrastructure, with an immediate focus on outpatient rehabilitative care non-profit seniors' care.

25 Ministry of Mental Health and Addictions, 2019, 50.

26 K. Reynolds, *Public-Private Partnerships in British Columbia: Update 2018* (Columbia Institute, 2018).

27 J. Brown, A. Arya, & A. Longhurst., How can we start to make Canada's long-term care homes about care, not profit? *Policy Options*, Sep. 15, 2021.

28 A. Longhurst, Privatization and Declining Access to BC Seniors' Care: A Urgent Call for Policy Change (Vancouver: Canadian Centre for Policy Alternatives, 2017); M. McGregor and L. Ronald, Residential Long-Term Care for Canadian Seniors: Non-Profit, For-Profit or Does It Matter? (Montreal: Institute for Research on Public Policy, 2011).

Implement the recommendations of *In Plain Sight* report on racism in health care

On November 30, 2020, Mary Ellen Turpel-Lafond released *In Plain Sight*, a report on addressing Indigenous-specific racism and discrimination in BC's health care system. The report includes 24 recommendations for action, all focused on addressing the unacceptable experience of Indigenous peoples in the province's health care system, as described in the report:

> Indigenous people want to see change. They want to be treated with professionalism, compassion, and respect. They want to be believed when they report health care concerns and symptoms. Participants want to see policies and actions in the health system that meaningfully address racism and discrimination, including an accessible, meaningful and safe feedback process regarding health care experiences. Indigenous people see the need for training among health care workers to counteract stereotypes.[29]

The report mirrors the findings of HSA's report, *Confronting Racism with Solidarity*, released in August 2020. The findings of the survey of BIPOC (Black, Indigenous, People of Colour) members is helping to guide the development of anti-racism and member engagement work, and is intended to inform development of tools and resources to equip HSA, stewards, and the broader membership with information needed to respond to issues of racism in the workplace.

HSA fully supports all recommendations.

RECOMMENDATIONS

15. That the BC government commit the necessary resources in Budget 2022 and beyond to implement the recommendations.

29 M. Turpel-Lafond, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care* (Addressing Racism Review, 2020), 31.

Increase provincial revenues and tax fairness

Income taxes represent one of the most progressive taxes available for government for funding the public services we all collectively depend on, including public health care. Strengthening the progressive income tax system and ensuring that wealthier households pay their fair share, will also help reduce widening income inequalities in BC. A large body of evidence indicates that reducing income inequalities can reduce health disparities between lower-income and higher-income groups. In fact, more equal societies have better population health.[30]

The previous government pursued massive cuts to personal and corporate income taxes of 25% and 3%, respectively. In total, between 2001 and 2010, provincial tax cuts amounted to $3.4 billion in lost revenue.[31] This period of regressive tax shifts significantly reduced BC's fiscal capacity to make investments in critical social programs and climate change measures. The Canadian Centre for Policy Alternatives calculated that if BC dedicated the same share of GDP to public spending in 2019 as in 2000, BC would have $7 billion more available each year.[32]

Eliminating health inequalities that result from poverty and income inequality, and improving population health outcomes, can result in significant cost-savings to the provincial treasury.

The current BC government has made progress increasing tax fairness in our province. In 2018/19, the government increased the rate from 14.7 to 16.8% for incomes over $155,000.[33] In January 2020, Medical Services Premiums (MSP)—a highly regressive tax—were fully eliminated and replaced with the Employer Health Tax. As a result of these changes, the Canadian Centre for Policy Alternatives found that "[f]or the bottom 90% of households, total provincial taxes fall from an average of 9.1% of income in 2016 to 7.9% in 2020. In contrast, for the most affluent 1% of households, the effective tax rate rises over the same period from 9.6% to 10.5%."[34]

In February 2020, the BC government announced a new personal income tax rate of 20.5% on taxable income over $220,000.[35] However, the troubling growth of severe income and wealthy inequality – and its effects on poor health – in our province merits further action to increase the progressivity of personal income taxes. Building on these positive measures, HSA recommends that the BC government build introduce an additional income tax bracket for the highest-income earners, which would create greater tax fairness and reduce health and income inequalities.

Table 3. Personal income tax brackets and rates, 2021 tax year

Taxable Income - 2021 Brackets	Tax Rate
$0 to $42,184	5.06%
$42,184.01 to $84,369	7.70%
$84,369.01 to $96,866	10.50%
$96,866.01 to $117,623	12.29%
$117,623.01 to $159,483	14.70%
$159,483.01 to $222,420	16.80%
Over $222,420	20.5%

30 R. Wilkinson and K. Pickett, *The Spirit Level: Why More Equal Societies Almost Always Do Better* (London: Penguin, 2009); K. Pickett & R. Wilkinson, Income inequality and health: a casual review, *Social Science & Medicine* 128 (2015): 316-326.

31 M. Lee, I. Ivanova & S. Klein, *BC's Regressive Tax Shift: A Decade of Diminishing Tax Fairness, 2000 to 2010* (*Canadian* Centre for Policy Alternatives—BC Office, 2015).

32 A. Hemingway, Reality check: Only BC's very richest paying higher tax rate, *Policy Note*, 2019.

33 C. Pawson, Why the most wealthy in BC are being hit with a higher income tax, *CBC News*, February 18, 2020.

34 A. Hemingway, Happy New Year—no more MSP! *Policy Note*, 2020.

35 I. Ivanova & A. Hemingway, Our take on Budget 2020, *Policy Note*, 2020. It should be noted that income tax brackets are cumulative, which means that individuals taxed on each portion of income earned at each (higher) tax rate for each bracket as per Table 3.

Source: BC Ministry of Finance

RECOMMENDATION

16. Build on February 2020 measures to increase provincial revenues and tax fairness, by introducing an additional income bracket for the highest-income earners.

Conclusion

The Health Sciences Association of BC respectfully submits these recommendations to the Select Standing Committee on Finance and Government Services for consideration.

Our recommendations are based on research evidence and the frontline knowledge of our 20,000 members. Highly-trained HSA members across rural and urban BC want to deliver the best care possible, but resource constraints and severe staffing shortages create significant challenges.

COVID-19 has shone a bright light on new and pre-existing pressures. We encourage urgent action, especially in the area of health science professional shortages, in order to tackle the mounting crisis.

BC remains a prosperous province and entered the COVID-19 crisis with the fiscal capacity to make significant investments in health care and social services. Making bold investments in services and new infrastructure will contribute to a strong economic recovery and a more resilient British Columbia.

Appendix A: Health Science and Social Service Professionals Represented by HSA

Health science and social service professionals represented by the Health Sciences Association of BC include:

- Medical Imaging Technologists
- Medical radiation technologist (x-ray), including general radiography, mammography, angiography, fluoroscopy, CT scans
- Nuclear medicine technologists
- Radiation technologists
- Magnetic Resonance Technologists (MRI)
- Physiotherapists
- Social Workers
- Occupational Therapists
- Registered Psychiatric Nurses
- Pharmacists
- Respiratory Therapists
- Anesthesia Assistants
- Registered Dietitians
- Health Records Administrators
- Diagnostic Medical Sonographers
- Cardiology Technologists
- Speech Language Pathologists
- Biomedical Engineering Technologists
- Psychologists
- Clinical Perfusionists
- Clinical Counsellors
- Child Life Specialists
- Rehabilitation Counsellors
- Counselling Therapists
- Electroneurophysiology Technologists
- Social Program Officer
- Recreation Therapist
- Supported Child Development Consultant
- Music Therapist
- Early Childhood Educator
- Vocational Counsellor
- Infant Development Program Consultant
- Medical Laboratory Technologists
- Dental Hygienists

Appendix B: Ministry of Health Priority Professions[36]

Strategic Priority Areas	Priority Professions for 2018/2019	Future Priority Professions
I. Primary Care Services	Nurse Practitioner	Registered Nurse
	Family Physician	Psychologist
	Licensed Practical Nurse (LPN)	Social Worker
	Occupational Therapist (OT)	
	Physiotherapist	
II. Adults with Complex Medical Conditions and /or Frailty	Health Care Assistant (HCA)	Registered Nurse
	Licensed Practical Nurse (LPN)	Rehabilitation Assistant
	Occupational Therapist (OT)	Dietitian
	Physiotherapist	Social Worker
		Medical Specialist
III. Surgical and Diagnostic Services[37]	Nurse (LPN and RN)	Anesthesiologist and GP Anesthesiologist
	Nurse Practitioner	Anesthesia Assistant
	Physiotherapist	Case Manager
	Perfusionist	Surgeon & GP with enhanced surgical skills
		Dietitian
		Counsellor
		Home Nursing Support
		Surgical Services Team
		Clinical Surgical Subspecialists
IV. Mental Health and Substance Use	Psychiatrist	Psychologist
	Registered Psychiatric Nurse	Social Worker
	Occupational Therapist (OT)	Clinical Counsellor
	Family Physician	Trained Peer Support
	Nurse Practitioner	Pharmacist
	Physiotherapist	Dietitian
		Naturopathic Medicine
		Recreation Therapist
		Music and Art Therapists
		Spiritual Services
		Traditional Chinese Medicine and Acupuncturist
		Cross-Cultural Liaison
		Vocational Expert
		Expert in Public Health
		Expert in Psychosocial Rehabilitation

Strategic Priority Area	Priority Professions
V. Cross-System Priority Professions & Service Areas	Diagnostic Medical Sonographer
	Paramedic (Emergency Medical Assistant)
	Dermatologist
	Specialty Nursing
Indigenous Health	Remote Certified Practice Nurse
	Dentist
	Dental Therapist
	Dental Hygienist
	Midwife
	Doula
	Traditional Healer, Elder and Knowledge Keepers
	Cultural Support Worker
	Aboriginal Patient Liaison/Navigator
Palliative Care	Palliative Care Specialist
	Pain and Symptom Management Specialist
	Family Physician with palliative care skills training
	Community Health Nurse with palliative care experience

36 Priority professions from Ministry of Health's *British Columbia Provincial Health Workforce Strategy, 2018/19 – 2020/21*. Highlighted professions are health science professions.

37 Although not identified in the Ministry of Health's 2018 Provincial Workforce Strategy as priority professions, other professions are being considered as priority professions based on COVID-19 and the surgical and diagnostic backlog.

HSA HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

@hsabc
info@hsabc.org
www.hsabc.org

HEALTH CARE AND COMMUNITY SOCIAL SERVICES WORKERS MISS OUT ON PRESUMPTIVE COVERAGE DESPITE WORKPLACE RISKS

"Knowing that social workers and other social service providers would be covered under presumptive coverage for PTSD and other mental illnesses related to our often painful and challenging work would be a relief. In my role I help people navigate large, unwieldy bureaucracies every day. Anything that could reduce that emotional and administrative burden for staff who are negatively impacted by their work would leave them more time to focus on their recovery."
– Gwyneth Jones, Social Worker

What is presumptive coverage?

In 2018 the NDP government introduced *The Workers Compensation Amendment Act*, adding a mental health disorder presumption for correctional officers, emergency medical assistants, firefighters, police officers and sheriffs. In early 2019 they expanded the coverage to also include nurses, health care aides, wildland fire fighters, and dispatchers.

Presumption is applied to those mental health claims made under 5.1 (1.1) of the *Workers Compensation Act.*[1]

Under the presumptive clause, when a worker from an eligible occupation receives a formal diagnosis of PTSD or another mental health disorder as a result of a work-related traumatic event or events, it is easier to advance a Workers Compensation claim.

Background

The Health Sciences Association applauds the government's decision to expand presumptive coverage to nurses and health care aides. This will reduce stress for workers, encourage them to get help when they need it, and remove onerous bureaucratic steps.

We know that the faster someone seeks help, the faster the recovery and the faster they are back at work.

However, there are a number of health care and community social services professionals currently not covered by the legislation who face ongoing workplace risks. In fact, workers in all sectors of work can experience work-related trauma.

Statistics reveal that acts of violence or physical force are the second highest cause of workplace related injury for workers in BC's healthcare sector.[2] Exposure to violence, or the potential of violence, has been clearly linked to PTSD and related mental health diagnoses.[3]

Overall, health care occupations are rated among the top professions in Canada for lost time claims.[4] Building robust supports for health care and community social service workers means that we acknowledge the very real toll workplace violence and traumatic events can take on a person's mental health.

Respiratory therapists, for example, deal with cardiac arrest and death on a day-to-day basis.[5] Social workers in health care often provide support to patients who have experienced trauma and abuse. Statistically, they experience high rates of burnout[6] and PTSD associated with their work.[7] Research points to elevated risks for suicidal ideation and depression for psychologists on health care teams.[8]

A recent study documents that across health science professionals, including diagnostic professionals, physiotherapists, occupational therapists, and pharmacists, female health care workers were found to have higher suicide rates than women in other occupations.[9]

Ultimately, current presumptive coverage regulations fail to account for the needs of all health care and community social services professionals who face substantial mental health risks as a result of work-related traumatic events.

How presumptive coverage is applied across Canada

In 2018 BC joined other provinces like Alberta, Ontario, New Brunswick, Manitoba and Saskatchewan in adopting presumptive coverage. [10]

Other provinces have extended presumptive coverage to include a diversity of health science professionals, not just nurses and health care aides. For example, in 2016, the Workers Compensation Board of Manitoba did not limit PTSD presumption to a specific occupation.[11] This has helped to destigmatize PTSD and has resulted in more streamlined access to supports – essential given the links between recovery and early intervention.[12, 13]

PEI and Saskatchewan grant presumptive coverage to all workers for a broad set of psychological injuries.

We are pleased BC has adopted an inclusive model of presumption that acknowledges an assortment of "mental disorders" that can arise as a result of workplace trauma – the presumption is not limited to PTSD alone.[14] This is important because trauma does not correlate with just PTSD diagnoses, but an assortment of diagnoses that can impact the health and wellbeing of workers.[15,16]

Application of the Presumption in 2019		**Jurisdiction**[17]													
BC		**AB**	**AB**	**SK**	**MB**	**ON**	**NB**	**NS**	**PEI**	**NL**	**QB**	**NV**	**NWT**	**YK**	
Description	Psychological Injury	√	√		√					√		X	X	X	
	PTSD			√		√	√	√	√		√	X	X	X	√
Occupation	All Workers		√		√	√				√	√	X	X	X	
	First Responders/ *or First Responders and* ***Limited Professions***	√		√			√	√	√			X	X	X	√

Presumption is working

Of the 4,404 new mental disorder claims reported to WorkSafeBC in 2018, 264 were submitted under the updated presumptive clause of the Workers Compensation Act.[18] 95% of these claims were allowed, where an allow/disallow decision was made.[19] These statistics speak to the success of presumptive coverage in helping workers to access the mental health supports they require.

Overall increases in acceptance rates for mental disorder claims in 2018[20] are a result of the presumptive clause for eligible occupations, and a general policy change that removes a restriction limiting the definition of a traumatic event to an "unusual and distinct" circumstance.[21,22] These positive changes recognize both acute trauma and the cumulative impact of ongoing trauma over the course of a worker's employment. For workers experiencing mental health injury, reducing barriers to advancing a WCB claim is critical.

Year	# Number of Mental Disorder Claims Allowed	% Percentage of Mental Disorder Claims Allowed
2016	1,253	54%
2017	1,351	55%
2018	1,516	62%

Mental health disorder claims for related occupations in health

Jan 1 2016 – Oct 30, 2018	Mental Disorder Claims
Nurses	579
Social and Community Service Workers	434
Nurse Aides, Orderlies and Patient Service Assoc.	217
Paramedical Occupations	330
Home Support Workers, Housekeepers and Related	93
Social Workers	62
TOTAL:	**1715**

*WorkSafeBC Data excludes Bullying and Harassment Claims[xx]

Claim rates are one indicator of the need for inclusion under the WCB presumptive clause. However, claim rates alone do not tell the full story of potential risk associated with an occupation and the need for proactive policy in the event of work-related trauma. It is critical to take into account the nature of work and potential risk faced by workers in the course of employment.

For example, sheriffs are currently included as an eligible occupation; however, less than ten mental disorder claim submissions were reported each year to WorkSafeBC for this occupational group in 2016, 2017 and 2018.[23] For the same years, fire fighters submitted 182 claims and police officers 161.

While health science professionals currently not included in the presumption reflect fewer claims than nurses, they too face considerable risks associated with their work.

This level of risk has been acknowledged in other jurisdictions. For example, after documenting high rates of disallowed PTSD claims for child protection workers, social workers, and mental health workers among other professions, the Government of Manitoba acted and granted presumptive coverage for PTSD to all workers in the province.

More broadly, across Canada, governments and unions emphasize stigma reduction as a critical goal of PTSD/psychological injury presumption in order to encourage more people to report trauma-related mental health injuries and to seek help when they need it.[24,25,26]

"As a respiratory therapist my average work day includes being a part of the worst day of someone's life. Maybe today I am initiating life support on a person who may never again live without that machine or I am securing the airway and breathing of a premature baby who may or may not survive being born too early. For the most part it is a tremendous honour to be a trusted care provider in such dire circumstances, but there are times when the armour wears thin and the case of the day hits a little too close to home."
– Trevor Whyte, Respiratory Therapist

Conclusion

We are asking the BC Government to expand presumptive coverage for mental health disorder claims that result from a workplace traumatic event to include the whole team of health care and community social service workers in BC.

For workers suffering from a psychological injury, presumptive coverage is an important pathway through the complex maze of the workers' compe >nsation system. A pathway that can reduce stress and stigma for workers in need.

We appreciate that there is a cost to the government's budget to expand presumptive coverage, but there is also a cost when a worker does not quickly get the support and resources they need after experiencing work-related trauma.

The province is currently facing a severe shortage of health care and community social services professionals. We need to ensure that workers filling these critical roles are protected and supported, and that includes reducing the barriers to accessing assistance upon receiving a mental health disorder diagnosis stemming from a workplace traumatic event.

They Support Us.
Let's Support Them.

Endnotes

1 Government of British Columbia. "Workers' Compensation Act," [RSBC 1996] 2019.

2 WorkSafeBC. "Claim Count by Incident Type." WorkSafeBC, 2019

3 Browne, Angela. "Violence against Women by Male Partners: Prevalence, Outcomes, and Policy Implications." American Psychologist 48, no. 10 (1993): 1077–87.

4 Association of Workers' Compensation Boards of Canada. "2017 Lost Time Claims in Canada." Statistics, 2019.

5 Johnson, Saumy. "Code Blue Calls: Role of Respiratory Therapist." Journal of Pulmonary and Respiratory Medicine 4, no. 4 (2014): 135.

6 Siebert, Darcy Clay. "Personal and Occupational Factors in Burnout among Practicing Social Workers: Implications for Researchers, Practitioners, and Managers." Journal of Social Service Research 32, no. 2 (2006): 25–44.

7 MacDonald, Heather A., Victor Colotla, Stephen Flamer, and Harry Karlinsky. "Posttraumatic Stress Disorder (PTSD) in the Workplace: A Descriptive Study of Workers Experiencing PTSD Resulting from Work Injury." Journal of Occupational Rehabilitation 13, no. 2 (2003): 63–77.

8 Kleespies, Phillip M., Kimberly A. Van Orden, Bruce Bongar, Diane Bridgeman, Lynn F. Bufka, Daniel I. Galper, Marc Hillbrand, and Robert I. Yufit. "Psychologist Suicide: Incidence, Impact, and Suggestions for Prevention, Intervention, and Postvention." Professional Psychology: Research and Practice 42, no. 3 (2011): 244–251.

9 Milner, Allison, Humaira Maheen, Marie Bismark, and Matthew Spittal. "Suicide by Health Professionals: A Retrospective Mortality Study in Australia, 2001-2012." Medical Journal of Australia 205, no. 6 (2016): 260–65.

10 Keefe, Anya, Stephen Bornstein, and Barb Neis. "An Environmental Scan of Presumptive Coverage for Work-Related Psychological Injury (Including Post-Traumatic Stress Disorder) in Canada and Selected International Jurisdictions." St. John's, NF: Centre for Occupational Health and Safety Research, 2018.

11 Workers Compensation Board of Manitoba. "PTSD Presumption." Presumption Details, 2019.

12 Keefe, Anya, Stephen Bornstein, and Barb Neis. "An Environmental Scan of Presumptive Coverage for Work-Related Psychological Injury (Including Post-Traumatic Stress Disorder) in Canada and Selected International Jurisdictions." St. John's, NF: Centre for Occupational Health and Safety Research, 2018.

13 Kearns, Megan C., Kerry J. Ressler, Doug Zatzick, and Barbara Olasov Rothbaum. "Early Interventions for PTSD: A Review." Depression and Anxiety 29, no. 10 (2012): 833–42.

14 Government of British Columbia. "Workers' Compensation Act," [RSBC 1996] 2019.

15 Y. Auxemery. "When Bullets Cause Psychological Injuries…An Essential Continuity of Care from Debriefing to Follow-Up. European Journal of Trauma and Disassociation, 1(3), 177-182, 2017.

16 W. Gnam. "Mental Disorders, Mental Disability at Work and Workers' Compensation." Victoria, BC: Royal Commission on Workers' Compensation in British Columbia, 1998.

17 Updated September 17th, 2019.

18 WorkSafeBC. "Mental Disorder Claims (Reported to WorkSafeBC 2016 to 2018)," 2019.

19 WorkSafeBC. "Mental Disorder Claims (Reported to WorkSafeBC 2016 to 2018)," 2019.

20 WorkSafeBC. "Mental Disorder Claims (Reported to WorkSafeBC 2016 to 2018)," 2019.

21 WorkSafeBC. "Mental Disorder Claims (Reported to WorkSafeBC 2016 to 2018)," 2019, page 2.

22 Mike Paine and Ed Dowling. "Mental Disorders Presentation: Strategic Engagements, WorkSafeBC," New Westminster BC, June 2019.

23 WorkSafeBC. "Mental Disorder Claims (Reported to WorkSafeBC 2016 to 2018)," 2019.

24 Nora Fien. "Manitoba's Changes to Workers Compensation Legislation Regarding Post-Traumatic Stress Disorder: Analysis and Legislative Process." Manitoba Law Journal. 40 (2), 1-27 ,2017.

25 Government of Saskatchewan. "Backgrounder: Amendments to the Workers' Compensation Act, 2013."

26 Rosemary Ricciardelli and Alan Hall. "A Call for Presumptive Legislation: Post-Traumatic Stress Disorder, Occupational Stress Injuries and the Well-Being of the Workforce." St. John's, NL: Memorial University of Newfoundland, 2018, page 8.