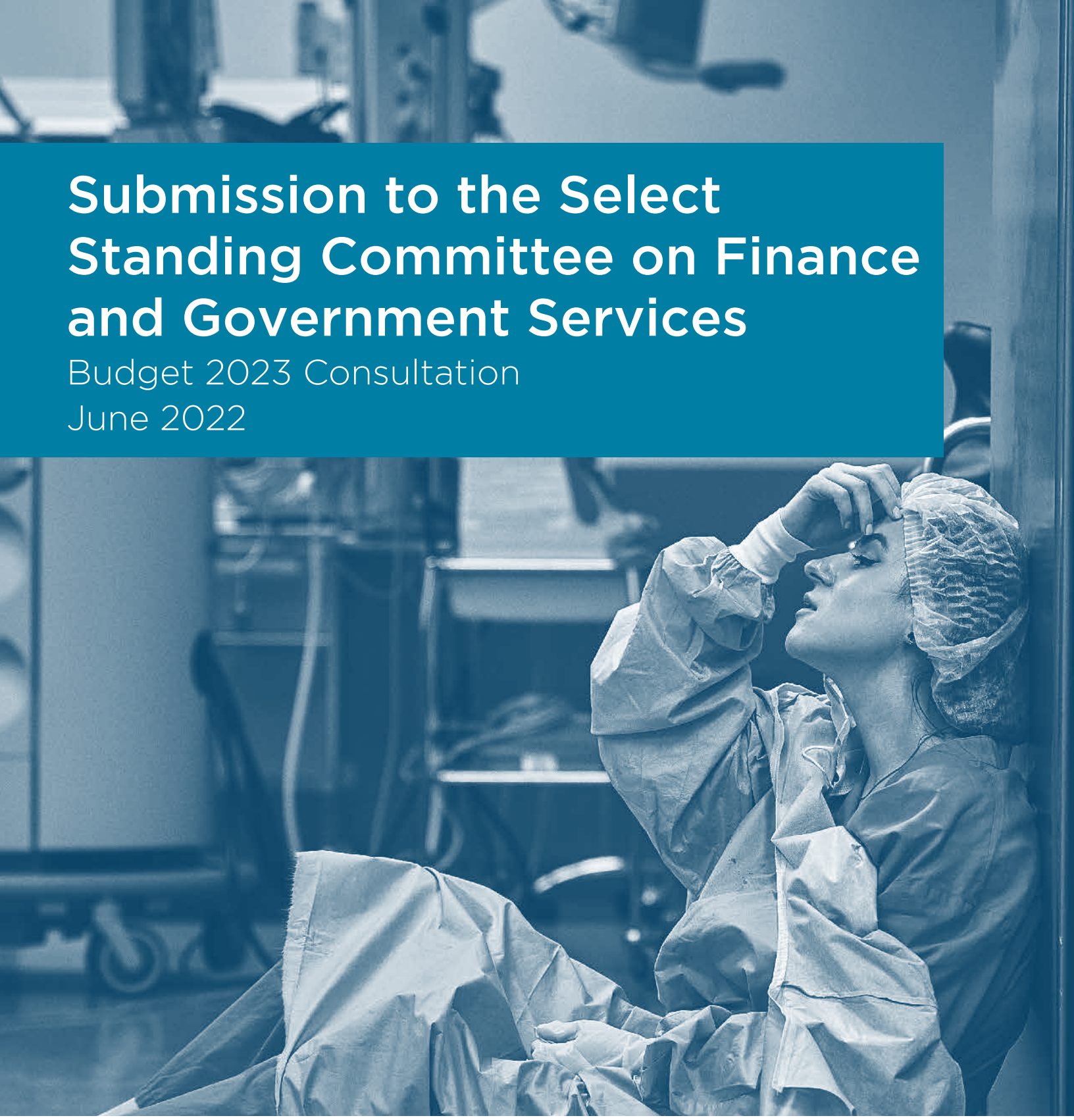


Submission to the Select Standing Committee on Finance and Government Services

Budget 2023 Consultation

June 2022

HSA

HEALTH SCIENCES ASSOCIATION

The union delivering modern health care

Contents

Message from President Kane Tse

Our public health care system faces professional shortages like never before. The staffing crisis is also a crisis in care.

Short-staffing, unfilled vacancies, and recruitment and retention challenges are constraining the province's ability to meet the health care needs of British Columbians.

Respiratory therapists, medical laboratory technologists, social workers, pharmacists, physiotherapists, and many others. It's not just doctors and nurses. It is the whole team of health care professionals.

Shortages of health science professionals in the public sector are creating barriers to the province's ability to provide timely access to health care.

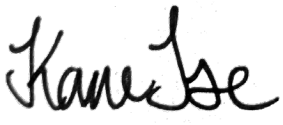
We are seeing medical laboratory closures. Emergency departments that cannot keep their doors open at night. Outpatient physiotherapy services that have been shuttered.

The current pressures on the public system are unsustainable – without addressing the root causes of the crisis. We urge the Committee and government to commit to ambitious improvements that will address the severe public sector shortages of health science professionals. We must shift from a reactive posture to a more sustainable, longer-term strategy that preserves and strengthens our public health system and the professionals we all depend on.

BC can no longer afford to move incrementally on the growing professional shortages crisis. We need bold action in Budget 2023.

On behalf of the Health Sciences Association of BC's more than 20,000 members, I respectfully submit our union's recommendations to the Select Standing Committee on Finance and Government Services for the Budget 2023 Consultation.

Sincerely,



Kane Tse, President
Health Science Association 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. HSA is also the lead union in the child development sector, representing over 1,000 pediatric therapists and specialized professionals at more than 15 non-profit agencies across the province.

Budget 2023: Worsening health care crisis demands bold action

When crisis hit BC's transportation infrastructure in November 2021, billions of dollars were immediately committed to address the problems.

We need the same urgency in addressing another critical infrastructure in our province – our public health care system. BC is in the midst of a health workforce crisis. We are a wealthy province, and the latest fiscal outlook demonstrates that we have significant budgetary capacity to invest in critical health care and social services.

Fiscal outlook

Fiscal year 2021/22 is expected to end with a deficit of $483m – much smaller than what was anticipated last year.[1] The projected deficit increases to $5.5b in 2022/23, and is expected to fall to $4.2b by 2023/24.[2] Provincial debt load is projected to increase under the three-year plan, but the debt-to-GDP ratio will be very manageable at 20% in 2022/23.

Budget 2022 again provides large pandemic contingencies and forecast allowances over the three-year plan of $3b (2022/23), $2b (2023/24), and $1b (2024/25).[3] These dollars will go towards paying down the deficit if they remain unspent at fiscal year end.

Operating spending is projected to decline as a share of our economy (nominal GDP) over the three-year plan, and from a high of 20.1% in 2020/21 down to 19.8% in 2022/23 and 18.7% in 2024/25.[4] This is a useful measure as it tells us whether BC's program spending is increasing (or maintaining) as the economy grows, regardless of the business cycles in the economy.

Health sector spending as a share of the economy (nominal GDP) is expected to come in at 7.5% in 2022/23 – down from a high of 8.3% in 2020/21.[5] It is projected to keep falling over the course of the three-year plan.

We urge historic investments in the health care and social services workforce and the care economy. As Alex Hemingway, senior economist at the Canadian Centre for Policy Alternatives - BC, writes:

> *[A] growing body of evidence tells us that spending on public services, social supports and physical and social infrastructure comes with major economic benefits. […] BC remains stuck in outdated economic thinking, which doesn't adequately account for the large benefits of public investment. While public spending increased temporarily during the pandemic, BC's most recent budget (Budget 2021) projects a gradual return to the status quo ante (in terms of public spending relative to GDP) over the next two years. For example, operating spending will have dropped from 21.5 per cent of GDP in 1999/00 to a projected 20.0 per cent of GDP in 2023/24. If we instead returned spending to 1999/00 levels, we'd have about $5 billion more available that year (and ongoing) to invest in urgent social and environmental priorities.*[6]

1 Budget and Fiscal Plan 2022/23 to 2024/25, p. 1.
2 Like the end of this fiscal year, the practice of conservative budgeting in BC is likely to result in smaller deficits in future years.
3 Unless these dollars are spent during the fiscal year they are allocated for, they will not be used for program spending and will go towards paying down the provincial debt.
4 Ibid., p. 175.
5 Ibid., p. 175.
6 Alex Hemingway, Why increasing government spending makes economic sense, Policy Note, Feb. 14, 2022.

Jobs in the health care and social services sector make up the second-largest share of total provincial jobs at 14 per cent (Table 1). Furthermore, health care and social assistance make up the greatest share of jobs in four of seven regions, and second-greatest or third-greatest in the remaining regions. 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 recovery and meeting urgent health and social needs.

Table 1: Share of total employed by industry, BC and economic regions, 2021

	British Columbia	Vancouver Island and Coast	Lower Mainland-Southwest	Thompson-Okanagan	Kootenay	Cariboo	North Coast and Nechako	Northeast
Wholesale and retail trade	15%	14%	16%	14%	14%	15%	14%	16%
Health care and social assistance	14%	15%	13%	16%	14%	16%	12%	9%
Professional, scientific and technical services	10%	8%	11%	6%	7%	5%	6%	4%
Construction	8%	8%	7%	11%	10%	8%	8%	12%
Educational services	7%	9%	7%	6%	8%	7%	8%	6%
Manufacturing	7%	4%	7%	7%	7%	11%	9%	4%
Accommodation and food services	7%	7%	6%	7%	6%	7%	9%	7%
Finance, insurance, real estate, rental and leasing	6%	5%	7%	6%	3%	4%	-	4%
Transportation and warehousing	5%	4%	6%	5%	2%	4%	9%	6%
Information, culture and recreation	5%	4%	6%	4%	4%	2%	-	-
Other services (except public administration)	4%	4%	4%	5%	4%	4%	-	6%
Business, building and other support services	4%	5%	4%	3%	2%	2%	-	-
Forestry, fishing, mining, quarrying, oil and gas	2%	2%	1%	3%	11%	6%	7%	11%
Agriculture	1%	1%	1%	1%	-	-	-	-
Utilities	1%	0%	1%	1%	-	-	-	-

Source: Statistics Canada, Table 14-10-0392-01 Employment by industry, annual (Jan. 7, 2022 release)

Address the severe shortage of public sector health science professionals and pediatric therapists

British Columbia is struggling with extreme 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.[7]

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

- Health science professionals working in chronically under-staffed workplaces are burning out due to workload and excessive overtime demands, which serves to accelerate the growth of shortages.
- COVID-19 testing in BC is limited by the severe shortage of medical laboratory technologists.
- 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 more manageable caseloads.
- 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 Ministry of Health and HSA have identified 14 professions in need of immediate action. These include medical laboratory technologist, anesthesia assistant, magnetic 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.

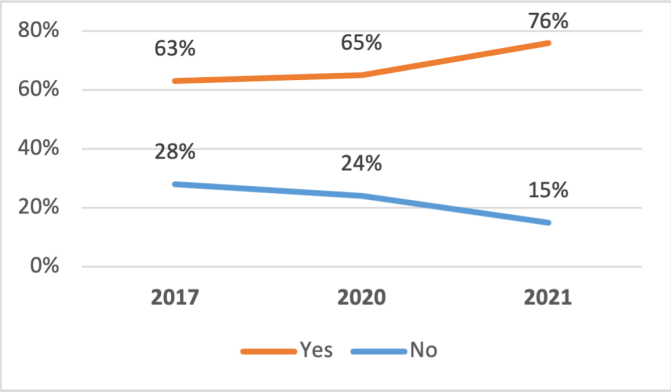
Many British Columbians have never heard of these professions, nor could they describe the critical role they play in our public health care system. Despite this lack of public awareness, health care cannot function without these professionals.

Because of unfilled vacancies and low staffing levels, many departments rely on overtime and casual staffing to deliver necessary services. Based on available health authority data, unfilled vacancies for occupational therapists and physiotherapists each increased by roughly 125% between 2014 and 2019.

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 workloads. Most concerning, 76% reported shortages in their profession, up from 63% in 2017 (Figure 1). Professional shortages have reached a breaking point.

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

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 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.

Many committee budget consultation reports have commented on the challenge facing our health care system stemming from the shortage of health science professionals.

Restructuring of services for children and youth with support needs adds urgency to addressing severe funding and staffing shortages

Child Development Centres (CDCs) provide therapy and services to more than 15,000 children and youth with support needs (CYSN) 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.

CDC services are currently being restructured through a Ministry of Child and Family Development process to create 40 "family connection centres" (FCCs) across BC. On May 10, 2022, MCFD released four Requests for Proposal (RFPs) for early implementation sites in Kelowna, Prince Rupert, Smithers, and Terrace.[8] Proponents must submit bids no later than July 22, 2022. A full provincial roll-out will begin in 2024, with up to 40 total FCCs expected. MCFD says that it will make adjustments as necessary based on the experience in the four early implementation communities.

The new funding and service delivery model will see the creation of Lead Agencies responsible for operating family connection centres. Lead Agencies will assume significant new operational pressures including the responsibility of transitioning all children and families who have been receiving individualized autism funding into the FCC. With this transition, it is important that MCFD commit to relational continuity of care (i.e., families can maintain their existing provider/s) and continuity of employment for specialized professionals working for CDCs.

Significant increase in baseline pediatric therapy staffing needed to improve access for early intervention therapies

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 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.

Early intervention funding is provided by MCFD through the Children and Youth with Support Needs (CYSN) funding stream, and includes early intervention therapies, infant development, supported child development and school age therapies. 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, 2020, and 2021 each made specific recommendations to

8 Government of BC, Process begins to select family connection centres, news release (May 10, 2022).

increase investment in early intervention services, increased funding was not provided. As a result, early intervention therapies continue to have the longest wait times among CYSN services, ranging from seven to 18 months. 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 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.

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.[9] Put another way, for every dollar invested in comprehensive early childhood development programming, 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.

The new FCC model centralizes funding for early intervention therapies into a single MCFD contract; however, it is unclear whether the new FCC model provides net-new funding for the sector.

HSA hopes to work with MCFD and CDCs to address the severe public sector shortage of pediatric therapists, and other concerns arising from this service restructuring.

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

The ongoing COVID-19 pandemic continues to place extraordinary pressures on acute care, making it difficult to 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. HSA applauds the government for its focus on increasing diagnostic imaging in the public system, including MRIs, and acquiring two private surgery clinics on Vancouver Island.[10] We know that the demand for these services is growing, especially with the pandemic backlog and an aging population. This achievement is a testament to the dedication of health science professionals.

But our members are exhausted and constantly working short-staffed. We simply do not have enough health science professionals to sustain the system as it currently exists. A sustainable long-term strategy requires having enough people to manage the work, and ensuring that we have designed the system to make the most effective and efficient use of health care providers (e.g., managing waitlists, referral processes, team-based care pathways).

The COVID-19 backlog demands bold steps to make team-based pre-surgical, perioperative, and post-surgery system improvements standard practice provincially. These public innovations, including administrative efficiencies by moving waitlists from individual surgeons' offices to centralized health authority waitlists, reduce public wait times.

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

9 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.

10 Government of BC, Delivering more imaging exams for people in British Columbia, media release (June 9, 2022); Cindy Harnett, Island Health to take over and expand two private clinics for day surgeries, Times Colonist (April 28, 2022).

system improvements standard practice provincially.[11] 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 provide timely diagnosis for as well as the capacity to meet the federal government's requirement of 20,000 tests/day for COVID-19 testing and emerging infectious diseases.

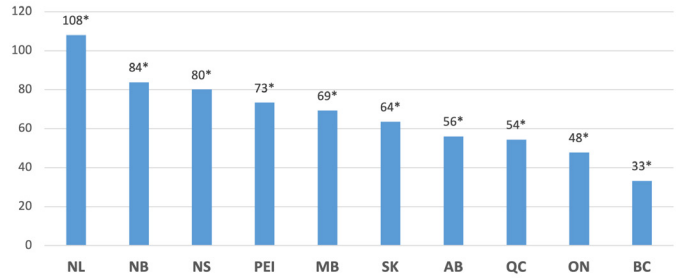
Medical laboratory technologists are skilled professionals necessary for analyzing specimens and delivering COVID-19 test results. Due to severely low staffing levels, lack of post-secondary training seats, and uncompetitive wages with other provinces, BC has the lowest number of medical laboratory technologists per capita among the provinces. In 2020, BC had 33 medical laboratory technologists per 100,000 population, significantly below all the provinces and the second-lowest, Ontario with 48 per 100,000 population (Figure 2).

Furthermore, BC faces a shortage of respiratory therapists who are essential to caring for patients with COVID-19 and other cardio-respiratory conditions.

Alarmingly, BC has the fewest respiratory therapists per capita among the provinces (Figure 3). 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.

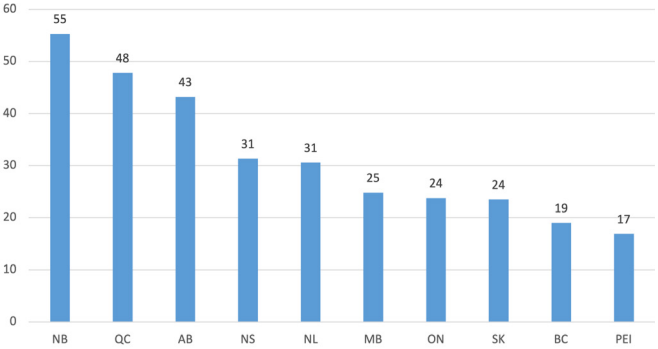
Respiratory therapists are specialized professionals who work with ICU teams to intubate patients, and they also play a vital role in hospital and outpatient settings in the areas of ventilator management, non-invasive ventilation therapies, respiratory assessments, management of patient oxygen needs,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

Figure 2: Medical laboratory technologists per 100,000 population, 2020



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 in 2020. Please use with caution.

Figure 3: Respiratory therapists per 100,000 population, 2020



Source: Health Workforce Database, Canadian Institute for Health Information; Statistics Canada, Demography Division.
BC and PEI counts may be understated due to the non-regulatory status of the profession in 2020. Please use with caution.

Some progress, but much more action is required

In 2019, the BC government took positive steps towards addressing health science professional shortages in the public sector. Forty new first-year physiotherapy and 24 occupational therapy training seats will open between 2020

11 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.

and 2022 across the province.[12] 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.[13] These two new programs build the province's training capacity by adding to the approximately 40 students trained at BCIT.

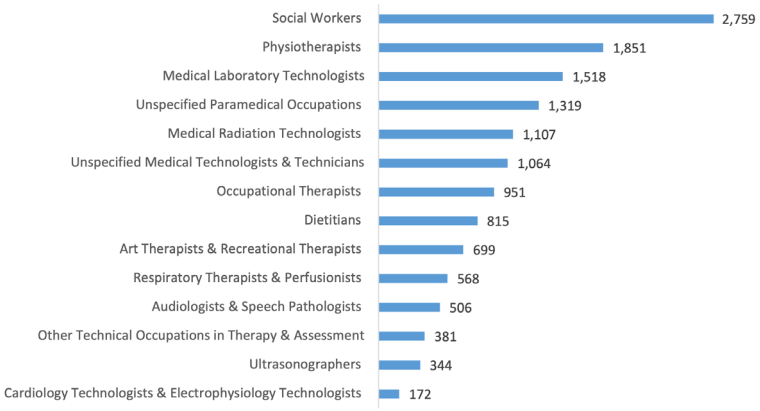
Budget 2021 provided $96 million in new funding over three years for expanded post-secondary training for nurses and health science professionals. In 2022, a Ministry of Health-funded BCIT bursary to support existing BCIT MRI students and HSA members complete their training was established.[14] As well, a direct-entry MRI certificate will also be launched in 2023.

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 providing competitive compensation and attractive workplaces for new graduations by ensuring that staffing levels permit professionals practice how they trained and do not cause moral distress and burnout. Baseline staffing levels must be increased across the board in order to recruit into the public sector.

Many health science professions are designated WorkBC High Opportunity Occupations, with thousands of job openings to be filled by 2029 (Figure 4). The vacancies are likely to increase as demand for health care increases.

Figure 4: WorkBC job openings, 2019 to 2029



One of the most profound challenges in public sector staffing 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 2020, including labour market (wage) adjustments needed to make a number of health science professions

12 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.

13 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.

14 Government of BC, Delivering more imaging exams for people in British Columbia, media release (June 9, 2022).

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 extremely 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%

Sources: Current BC and Alberta public sector collective agreements.

Conclusion

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

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, and will play a critical role in our post-pandemic economic recovery. Investing in the health care and social services workforce makes solid economic sense. Most importantly, they serve an urgent need in our province, and they are good jobs that support families in communities across the province

RECOMMENDATIONS

1. Address the severe shortages of public-sector health science professionals by increasing: wages to be competitive with other provinces and the private sector; post-secondary training; work satisfaction with higher staffing levels. Professions include medical laboratory technologists, physiotherapists, occupational therapists, diagnostic medical sonographers, pharmacists, respiratory therapists, anesthesia assistants, speech-language pathologists, MRI technologists, social workers, dietitians, radiation therapists, radiation therapy services technologist, and cardiovascular perfusionist.

2. 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.

Improve occupational health and safety in health care and social services

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 cleaning indoor air and PPE

SARS-CoV-2 is predominately spread through tiny particles called aerosols.

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, which led HSA to call 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.[15] 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.

However, there remains significant risk to occupational health and safety as a result of Public Health changing definitions and infection prevention and control guidelines.

In December 2021 and January 2022, the BCCDC and Public Health in each health authority implemented dramatic changes to Infection Prevention and Control (IPAC) guidelines without any communication or engagement with HSA. Effectively, the changes meant a significant increase in the risk of exposure and infection for our members working in health care settings. These changes included:

- discontinuation of dedicated nursing for COVID-19 positive patients;
- discontinuation of dedicated housekeeping staff for COVID-19 patients, COVID-19 positive cohorts, and outbreak units;
- discontinuation of asymptomatic testing of staff working on outbreak units;
- no longer cohorting COVID-19 positive patients;
- allowing COVID-19 positive patients to share multi-bed rooms with COVID-19 negative patients (and using droplet precautions);

The discontinuation of these precautionary measures puts our members at increased risk of exposure to COVID-19. These changes were introduced at the same time BC IPAC guidelines continued (and still continue) to refuse to implement airborne precautions based on the global scientific consensus on airborne transmission. The cumulative effect of these changes in health care settings is elevated risk to our members.

The above IPAC changes are at odds with the pandemic realities we continue to face. COVID-19 continues to spread rapidly and widely, and health care workers are being exposed unnecessarily. Relaxed cohorting, combined with privacy rules, mean that professionals are not likely to be aware that someone is positive. Furthermore, the extremely high levels of COVID-19 in the community make it very likely that members will be routinely coming into contact with positive patients or co-workers. In many cases, the hierarchy of controls, such as engineering controls, are not available or even possible to provide the appropriate level of protection to our members and others.

The most effective risk prevention control at the top of the hierarchy is "elimination" of the hazard, and yet there no longer public health measures in place to help eliminate and reduce the spread of COVID-19 in communities (and by extension in health care settings): contact tracing ceased in health care and community settings; PCR testing is limited to small segments of the population; and, isolation guidelines have been shortened to five days or "until you feel well enough to return to your normal activities" (even when evidence demonstrates Omicron infectiousness for up to 10 days) Put simply, the hierarchy of controls is vastly different now than it was in earlier stages of the pandemic. This

15 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).

leaves our members with fewer protections, and underscores the importance of barrier-free access to N95 respirators.

With severe staffing shortages and the continuing high burden of COVID on hospitals, continuing to require a point-of-care risk assessment presents practical barriers to access (even if N95s are provided as per the provincial mask use policy). Protecting health care workers from infection must be paramount, both in terms of

protecting their health as well as preventing additional pressure on a very strained health system and workforce.

BC's poor record collecting and disclosing COVID-19 cases among health care workers makes it difficult to fully understand where transmission is occurring. However, WorkSafeBC claims data provide a snapshot of the effects of COVID-19 on frontline staff. Since the beginning of the pandemic until April 30, 2022, there were 9,920 allowed claims—the majority (5,260 or 53%) were in health care and social services.[16]

COVID-19 presents an opportunity of a generation to improve occupational health and safety in response to one of the most transmissible pathogens in human history – SARS-CoV-2. HSA urges government and employers to rise to this occasion through a focus on improving indoor air quality through ventilation and air filtration.

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 in very challenging situations. On any day, these workers may face one or more traumatic events on the job that can result in a psychological injury or illness. However, they face barriers to quickly accessing the support they need to recover. The pandemic has added very significant psychological strain on health and social services professionals. In a 2021 survey of our members, 86% reported that the pandemic has had a somewhat or very negative impact on their mental health.

We know that the faster someone receives support, the faster their recovery. It also means they can return to work faster.

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

We urge the BC government to expand WorkSafeBC presumptive coverage to all health care and community social service professionals.

There is no cost to the government's budget to expand presumptive coverage as WorkSafeBC compensation is fully funded by the employer assessments into the "accident fund". There is significant savings fro government as those not receiving appropriate compensation and treatment end up supported by public services including health care and social assistance.

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 injury diagnosis stemming from the workplace.

RECOMMENDATIONS

1. HSA recommends that the Ministry of Health revise the provincial mask use policy to allow any health care workers to obtain an N95 respirator (or equivalent or higher protection) without a point-of-care risk assessment.

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

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

16 WorkSafeBC, COVID-19 claims data (claims as of April 30, 2022).

Rebuild public rehabilitative care in BC

A 2021 HSA report examined the state of public rehabilitation services for patients requiring therapy from debilitating illness, chronic disease, injury or recovering from surgery.[17]

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.

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 from 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).[18]
- 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.[19]
- 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.
- 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.

RECOMMENDATION

1. 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.

17 HSABC, HSA research examines widespread staffing shortages, erosion of public rehab care, news bulletin (October 22, 2022).
18 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.
19 Canadian Institute for Health Information, Physiotherapists in Canada, 2019 — Data Tables, 2020; BC Stats population estimates.

Protect the health care workforce by preventing COVID-19 spread

SARS-CoV-2 variants have revealed the necessity of both vaccination and public health protections to mitigate transmission and preserve health care services. Each wave takes a greater toll on health science and social service professionals working on the frontlines of public health care and social services. Vaccination and prior infection do not provide long-lasting immunity or protection against Long COVID risk.

Each wave adds workload pressures, (re)infection and Long COVID risk, and psychological stress on an already-stretched workforce. Health science professionals have been on the frontlines of the pandemic two and half years now. Surveys of HSA members revealed the extent of pandemic burnout and dangerous working and caring conditions:

- 70% reported that their workload has increased.
- 86% reported that the pandemic has had a somewhat or very negative impact on their mental health.
- 52% of respondents feel that staffing shortages are creating unsafe working conditions and/or risks to patient care and safety all or most of the time – and a further 30% say risks to patient care and safety is happening some of the time.

While heavy workload and burnout pre-date the pandemic, these issues have reached a crisis. 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. Late spring and early summer patient volumes for acute care are extraordinary, foreshadowing an extremely dire situation facing hospitals in fall and winter if COVID-19 pressures are not reduced.

As the WHO, Public Health Agency of Canada, and the last two years have demonstrated, jurisdictions are likely to require the strategic use of public health measures to protect our health services and workforce from being overwhelmed (called a "vaccine-plus" strategy), with a focus on testing, indoor ventilation and filtration, and indoor mask use. These public health tools can suppress transmission and prevent infection,[20] which will likely be necessary for the foreseeable future in order to:

- reduce the severe strain on hospitals and the health workforce, especially in ICUs;
- reduce mortality, morbidity, and severe outcomes from COVID-19, which disproportionately impact lower-income people;[21] 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).[22]

Environmental interventions, such as indoor air quality improvements and monitoring, should involve Joint Occupational Health and Safety Committees in each workplace. These committees, comprised of frontline workers, can provide valuable expertise when it comes to identifying higher-risk settings where ventilation and air filtration improvements are most needed. Professional engineers must also be involved in this work.

Furthermore, adequate paid sick leave is required to prevent the spread of disease. In January 2022, BC brought in five employer-paid sick days. While this is an important recognition that paid sick leave is required to prevent the spread of disease, it falls short of the ten days that health experts, economists, the BC Federation of Labour and HSA have called for.

RECOMMENDATIONS

1. Prevent transmission of COVID-19 in health care and social service workplaces (e.g., monitoring, ventilation, and filtration of indoor air, indoor masking, and, access to PCR testing).
2. Legislate 10 employer-paid sick days, which is recognized by health experts and economists, as the minimum necessary to prevent the spread of disease and promote individual and population health.

20 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.
21 Canadian Institute for Health Information, COVID-19 hospitalization and emergency department statistics, August 2021.
22 Canadian Institute for Health Information, 2021.

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 – is expected to total $8.6 billion from 2022/23 to 2024/25.[23] 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."[24] 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 historic capital investments to renew and expand outpatient rehabilitative care, 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.[25] 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.[26]

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, art and music 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 and therapy.

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

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

2. 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.

23 Budget and Fiscal Plan 2022/23 to 2024/25, p.67.
24 K. Reynolds, *Public-Private Partnerships in British Columbia: Update 2018* (Columbia Institute, 2018).
25 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.
26 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.*[27]

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.

RECOMMENDATION

1. That the BC government commit the necessary resources in Budget 2023 and beyond to implement the recommendations made in the *In Plain Sight* report.

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

Improve collection and public reporting of COVID-19 and race-based data

Throughout the pandemic, HSA has been at a significant disadvantage in understanding the COVID-19 impacts on our members and their workplaces due to limited and inconsistent collection and sharing of data by the BCCDC, Ministry of Health, and health authorities. We recognize the pandemic has created significant challenges for public sector organizations. However, we see this pandemic as an opportunity to review data collection and sharing practices, and make a new commitment to improving collection and public reporting of health-related data, including de-identified race-based data.

One of the few data sources to understand the impact of COVID-19 on health care workers is the BCCDC "COVID-19 Cases in Health Care Workers in BC" report. An updated report has not been publicly shared by the BCCDC since October 28, 2021. Collecting and regularly reporting these data should be prioritized.

We also echo calls from advocacy organizations for the BC government and Ministry of Health to begin collecting and reporting de-identified race-based data. As it relates to data collection and public reporting, we urge the government to fully implement the recommendations of the TRC Calls to Action and the *In Plain Sight* report on Indigenous-specific racism in health care.

In particular, we see an opportunity for government and employers to collect better data to understand their workforce and barriers to the recruitment and retention of employees who identify as Black, Indigenous, and people of colour.

RECOMMENDATION

1. We urge the BC government to improve collection and public reporting of COVID-19 cases in health care workers and race-based data in health care.

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.[28]

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.[29] 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.[30]

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.[31] 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%."[32]

In February 2020, the BC government announced a new personal income tax rate of 20.5% on taxable income over $220,000.[33] 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 introduce an additional income tax bracket for the highest-income earners, which would create greater tax fairness and reduce health and income inequalities.

RECOMMENDATION

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

28 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.

29 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).

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

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

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

33 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.

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 more than 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 are creating moral distress and burnout.

We urge the Committee to recommend that government make 2023 a budget that will make unprecedented investments in the health care and social service workforce.