HEALTH SCIENCES ASSOCIATION

The union delivering modern health care hsabc.org

Submission to the Government of BC

COVID-19 Lessons Learned Review

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Contents

Message from HSA President Kane Tse 3
Introduction 4
Improving BC's response to the pandemic 5
PHO orders and BC's labour relations regime 5
Single-site order and Single-Site Transition Framework (SSTF) 6
Mandatory vaccination order for health care workers 7
Temporary pandemic pay 8
Occupational health and safety 8
Aerosol transmission and access to N95 respirators 8
Changes to Infection Prevention and Control guidelines 11
Presumptive coverage for all health care and social service professionals 12
Access to COVID-19 PCR testing to prevent workplace outbreaks and support LTD claims 13
Urgent action needed to address health science professional shortages 14
Some progress, but more government action is required 16
Prevent transmission of COVID-19 to protect the health system and workforce 18
Improve collection and public reporting of COVID-19 and race-based data 19
Conclusion 19

Message from HSA 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.

COVID-19 has created immense challenges for our public health care system – it has exposed its strengths and its challenges.

We encourage government to use this consultation as an opportunity to hear from frontline health care professionals about how to improve the ongoing pandemic response.

We also hope that government sees this as a moment to commit to deeper investment in our public health care system and its workforce. 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 a caring team of health care professionals.

Our public health system and community social services face many challenges – and now is the time to make the improvements that will foster resilience now and into the future.

On behalf of the Health Sciences Association of BC's 20,000 members across the province, I respectfully submit our union's submission to the *COVID-19 Lessons Learned Review*.

Sincerely,

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 1,000 members at more than 15 non-profit organizations 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 feedback on the provincial response to the COVID-19 pandemic, and recommendations for improvement. We thank the government for considering the perspectives of frontline health science and social service professionals who are committed to improving health and social services for everyone.

Improving BC's response to the pandemic

There is no question that the COVID-19 pandemic presented government with a challenge of a generation. The pandemic has strained our health care system like never before.

As the pandemic enters the third year, we know that it is taking an immense toll on frontline health care and social service professionals. While we all want the pandemic to be over, we are reminded by the World Health Organization that this global public health emergency is not over.[1] However, at the two-year mark, it is an important time to reflect on what has been working and where improvement is needed.

HSA appreciates that this review provides an opportunity to share with provincial government where the pandemic response could improve. As much as we would like COVID-19 to go away, it is very much still with us. Many of the issues discussed remain areas of concern where improvement is needed.

PHO orders and BC's labour relations regime

The pandemic presented government and public health officials with an unprecedented need to respond in order to prevent and control disease transmission. The public health response has been central to government's broader pandemic policy response. And while we appreciate the need for difficult decision to be made, the PHO decision-making process and the orders themselves have been at odds with BC's established labour relations regime.

In BC, the vast majority of publicly funded health care services are provided by unionized workers working under one of four multi-union and multi-employer master collective agreements. These include the Health Science Professionals Bargaining Association (HSPBA) (led by HSA), the Facilities Bargaining Association (led HEU), the Community Health Bargaining Association (led by BCGEU), and the Nurses' Bargaining Association (led by BCNU). This sectoral labour relations structure has been in place in BC since the late 1990s.

Unfortunately, Public Health orders functionally altered negotiated collective agreements and the Provincial Health Officer's (PHO) decision-making processes disregarded existing labour relations structures at a time when vigorous engagement with unions representing frontline health care workers has been needed. The collective agreement as well as existing labour relations structures have allowed unions, government, and employers to jointly identify and address challenges.

[1] MSNBC, "WHO says COVID still a global public health emergency even as deaths fall to lowest level in two years," April 13, 2022, https://www.cnbc.com/2022/04/13/who-says-covid-still-global-health-emergency-even-as-deaths-fall-to-lowest-level-in-two-years.html.

In the case of the HSPBA, HSA routinely engages with the Health Employers Association of BC (HEABC), health authorities, and the Ministry of Health Sector Workforce Division on labour relations, occupational health and safety, policy and service delivery. This existing labour relations regime, predicated on the HSPBA master collective agreement negotiated between the HSPBA and HEABC, has provided a structure for HSA to work jointly on matters with employers and government in ways to improve public health care delivery while also respecting the freely negotiated rights of HSA members under the collective agreement.

While HSA recognizes the pandemic has represented a new challenge for government, requiring rapid response, PHO decisions and orders have rarely, if ever, consistently respected this existing labour relations regime that is intended to provide unions, employers, and government to constructively and jointly address matters that have collective agreement implications and affect the wellbeing of our members.

Unfortunately, over the last two years, and with the exception of early work developing the Single-Site Transition Framework, PHO decisions and orders have consistently disregarded BC's existing health sector labour relations regime. The PHO's top-down decision-making, without involving labour, has provided little or no opportunity for constructive engagement and troubleshooting. It has left our members frustrated when decisions are made without advanced warning or adequate communication.

Single-site order and Single-Site Transition Framework (SSTF)

In early 2020, the PHO and Ministry of Health identified the need to restrict staff movement between long-term care homes in an effort to reduce the potential for transmission and outbreaks. A single-site transition framework (SSTF) was negotiated by the Ministry of Health, HEABC, and the bargaining associations representing unionized workers in the long-term care homes, assisted living residences, and mental health facilities. This formed the basis of the labour adjustment underpinning the PHO's single-site order. The MOH and HEABC (representing employers) worked with bargaining associations to develop a framework that would be workable – one that both met the aims of Public Health and that endeavoured to minimize the impact on collective agreement rights.

The single-site order helped reduce transmission and outbreaks in long-term care, but it has also had unintended negative consequences for residents who rely on care from health science professionals. The single-site order revealed low overall staffing levels in seniors' care, with the greatest concerns in the for-profit care homes. 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 shortages and insufficient funding for specialized care provided by these professionals.

Our primary concern is that the single-site order has functionally altered freely negotiated collective agreement rights. Although the order is set to expire in January 2023, the pandemic context has changed significantly and the public health rationale for the single-site order is less clear. HSA is concerned that while the pandemic context has dramatically changed, the single-site order remains in place and continues to infringe upon the collective agreement rights of our members.

Specifically, it is now globally recognized that SARS-CoV-2 is an airborne virus and aerosol inhalation is the predominant mode of transmission (scientific consensus that has emerged following the April 2020 single-site order), good ventilation/air cleaning, the use of respirators, and asymptomatic staff testing are widely recognized as effective mitigations to reduce transmission and outbreak. With this knowledge of how to prevent transmission, the rationale for the single-site order is not as it was in early 2020. Furthermore, Public Health is no longer declaring outbreaks with an outbreak response in situations that would have been considered outbreaks previously, so it is hard to reconcile the continuation of the single-site order when these very fundamental precautions are not even employed.[2]

Unlike other bargaining associations and unions, the HSPBA and HSA members have been uniquely impacted by the SSTF. The single-site order has undermined our ability to represent our members. Due to the very low baseline staffing levels of health science professionals in long-term care homes, our members routinely worked across multiple LTC homes. While the current guidelines for the single-site order limit our members from working within a geographic cluster of facilities, the order continues to restrict our members' ability to obtain work as they are entitled under the collective agreement. This is not the case for other professions and the unions that represent them, as these professions can now easily find full-time work in one facility.

HSA would like to see all collective agreement rights restored.

Mandatory vaccination order for health care workers

HSA recognizes the importance of vaccination in fighting the pandemic. At the same time, as a union, we have an obligation to represent our members to the fullest extent possible as it relates to the collective agreement.

Similarly, the manner in which the mandatory vaccination order was developed and implemented provided HSA with very little time for engagement. Had the PHO and MoH engaged HSA earlier in the process we feel that we could have worked with the PHO, MoH, and employers on ways to appropriate redeploy members without having to resort to termination. At a time of already-low morale and a very strained health system, we found that the termination of health care workers could have been largely avoided. It is unfortunate that this could not have been avoided, especially as we knew fairly early that vaccination itself does not prevent COVID-19 transmission. Since doubly and triply vaccinated individuals

[2] CTV News Vancouver, "As COVID-19 spreads, few 'outbreaks' declared in BC care homes," March 23, 2022, https://bc.ctvnews.ca/as-covid-19-spreads-few-outbreaks-declared-in-b-c-care-homes-1.5832349 (accessed April 13, 2022).

can spread COVID-19 much more efficiently with new variants of concern, it is unfortunate that so many health care workers have been terminated at a time when there are staffing shortages across the health system.

The mandatory vaccination policy should be revisited based on the current context. Again, we regret that the PHO and MoH did not engage early in this decision-making process in order to identify strategies that could prevent the termination of health care professionals.

Temporary pandemic pay

The BC government provided more than 250,000 frontline workers with temporary pandemic pay as a lump-sum payment of about $4 per hour for a 16-week period, starting on March 15, 2020. We appreciate the government's recognition of the important work and dedication of frontline health care professionals who have put their own health on the line at a time of great stress and uncertainty.

However, it is unfortunate that the process of disbursing the temporary pandemic pay in a timely manner became such an operational challenge for employers. This long delay in providing members with pandemic pay created frustration that could have been avoided if disbursement was done in a moretimely manner. Adding to this frustration was the fact that our members have been excluded from other temporary wage supplements that have been provided to nurses. Our members are consistently working short-staffed and with chronic shortages but do not receive a working short premium like their nursing colleagues working next to them. Between April 2020 and July 2021, over $140 million has been paid out to nurses through the working short premium.

Occupational health and safety

Aerosol transmission and access to N95 respirators

Now in the sixth wave, HSA maintains the position that N95 respirators (or equivalent or higher protection) should be available to all health care workers in all health care settings without the need for a point-of-care risk assessment. Further, no health care worker should be denied access to a respirator, regardless of occupation or health care setting.

HSA was the first health care union in BC to advocate that health care workers have unrestricted access to N95 respirators upon a point-of-care risk assessment. In March 2020, HSA asked Dr. John Murphy, an occupational hygienist and Adjunct Professor at the University of Toronto's School of Public Health, to review the scientific literature on aerosol transmission of COVID-19 and its implications for personal protection equipment. In the March 2020 review and subsequent October 2020 update, Dr. Murphy concluded that health care workers should have access to N95 respirators based on the precautionary principle and weight of the evidence.

Since Dr. Murphy's review, there is now incontrovertible evidence that aerosol transmission is the *primary* mode of transmission, and that airborne precautions are necessary to protect health care workers. Consensus articles have been published in major scientific journals conclusively stating that COVID-19 is an airborne pathogen. Importantly, the WHO, US CDC, European CDC, and Public Health Agency of Canada acknowledge the airborne nature of COVID-19. Inhalation of aerosols, which can build up to dangerous levels in poorly ventilated spaces, are now accepted by these public health agencies as the primary mode of transmission. Public Health Ontario issued updated guidance in December 2021 recommending that all health care workers providing care to *confirmed or suspected* COVID-19 patients wear N95 respirators (or equivalent or greater protection). Despite this, BC PHO and BCCDC have still not acted on this science, which would require shifting from droplet to airborne precautions.

The BCCDC and PHO's position has consequences for health care workers and patients. Since the definition for a health care facility outbreak is now a subjective determination by the medical health officer (previously an outbreak was defined as one or more cases among staff or patients), current outbreak data are now longer reliable. However, prior to moving to a subjective definition, the lack of airborne precautions was obvious when examining outbreak data. From December 24, 2021, to January 10, 2022, active health care facility outbreaks rapidly increased from two to 43. This clearly demonstrates that droplet precautions were not preventing transmission and infection among health care workers and patients in health care settings.

COVID-19 cases among health care workers also indicate that the refusal to implement airborne precautions has contributed to preventable infections among health care workers. Between June 18, 2021, and October 28, 2021 (the most recent publicly available data), 2,817 additional health care workers were infected.[3]

While BC has limited data on exposures and infections among health care workers, WorkSafeBC claims data – representing workers' compensation claims for workplace-acquired infection – also show a significant increase in workplace-acquired COVID-19. In 2020, 1,766 WorkSafeBC total claims in Health Care and Social Services sectors were registered.[4] This increased to 5,987 by March 31, 2022 – an increase of 4,221 or 240%.[5]

In response to concerns from members about BC's refusal to acknowledge airborne transmission and provide unrestricted access to N95 respirators, HSA surveyed its members on PPE, access to N95 respirators, and Infection Prevention and Control guidelines in hospital settings in January 2022.[6]

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[3] Calculations from BCCDC, COVID-19 cases in healthcare workers: Jan 1, 2020 - Oct 28, 2021 and COVID-19 cases in healthcare workers: Jan 1, 2020 - June 18, 2021.

[4] WorkSafeBC, "COVID-19 claims registered in 2020," April 23, 2021, https://www.worksafebc.com/en/covid-19/claims/covid-19-claims-by-industry-sector/covid-19-claims-registered-in-2020 (accessed April 13, 2022).

[5] WorkSafeBC, "COVID-19 claims data," March 31, 2022, https://www.worksafebc.com/en/covid-19/claims/covid-19-claims-by-industry-sector (accessed April 13, 2022).

[6] Survey results are available here: https://www.hsabc.org/news/hsa-survey-reveals-widespread-concerns-about-staffing-levels-patient-safety-and-access-n95s

We appreciate that the Ministry of Health, upon receiving our concerns about frontline workers denied access to respirators upon point-of-care risk assessment, facilitated conversations directly with employers and the union, in an effort to remind employers of the provincial mask use policy of providing unrestricted access to respirators upon an individual's point-of-care risk assessment. The PHO did not acknowledge or respond to the union's concerns nor engaged employers regarding the provincial mask use policy. Rather, HSA's concerns, expressed by frontline members, were addressed via existing labour relations structures.

This has been the consistent experience for HSA: the PHO has not engaged HSA on important matters related to public health orders and occupational health and safety, despite the PHO's decisions having significant implications for health care workers. This has raised numerous practical challenges for HSA to provide representation to its members when government – via the PHO – have chosen not to systematically engage unions or communicate orders. This had led to significant frustration among our members who are on the frontlines providing critical health care service to British Columbians – at risk to their own health and safety – but are often the last to be informed about public health orders, changes to IPAC guidelines or other matters.

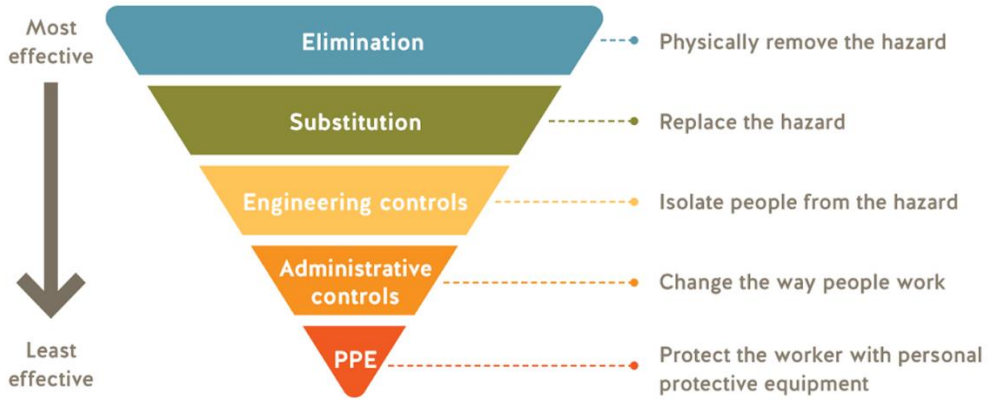
The continued refusal by the PHO and the government to accept – and act on – the science of aerosol transmission is extremely concerning because it has significant implications for the occupational health and safety of health care workers. We urge the PHO and government to accept the global scientific consensus and implement airborne transmission mitigations, including provision of respirators as baseline protection and investing in ventilation/air filtration improvements and ongoing monitoring of CO2 levels in health care settings.[7]

Importantly, engineering controls – including the use of ventilation and air filtration – are critically important in the hierarchy of controls in preventing exposure risk (see graphic next page). The importance of mitigating airborne transmission is paramount especially as there are few other measures in the hierarchy of controls to help prevent exposure risk to our members (see next section). The hierarchy of controls is foundational to mitigating health hazards in workplaces.

The PHO and government's refusal to act on the global scientific consensus on aerosol transmission is unacceptable and remains an ongoing concern. Communicating accurately and clearly to health care workers and the public how SARS-CoV-2 spreads should be of paramount concern to the PHO and government.

[7] Science briefs and information about the White House's "Clean Air Buildings Challenge" can be found here:
https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html
https://www.epa.gov/indoor-air-quality-iaq/clean-air-buildings-challenge

The hierarch of controls (WorkSafeBC)



Changes to 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 and the maintenance of droplet precautions 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 our members are being exposed when it could be prevented. 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 (see above), 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 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.

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.

Presumptive coverage for all health care and 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 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 urgent.

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 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.

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 the workplace.

We urge government to expand presumptive coverage to include all health care and community social service professionals under the Workers Compensation Act Mental Disorder Presumption Regulation.

Access to COVID-19 PCR testing to prevent workplace outbreaks and support LTD claims

Throughout the pandemic, BC's testing rate has been well below the most populous provinces. For example, BC's PCR testing rate has been nearly one-third of Ontario's and about half of the Canadian average (see table). In order to prevent and control transmission, and prevent new variant-driven waves that continue to overwhelm hospitals, the province must increase and maintain access to rapid and PCR testing for health care workers and the public.

Rapid tests are an effective public health tool in addition to PCR tests, which provide higher sensitivity and can be used for health care workers and as a confirmatory diagnostic tool. Declining access to PCR testing beginning in summer/fall 2021, and significantly reduced by December 2021, made it more difficult for health care workers to access testing should they require a positive PCR test to support long-term disability (LTD) claims. We appreciate that the BCCDC March 23, 2022 *COVID-19: Viral Testing Guidelines for British Columbia* document indicates that health care workers remain eligible for PCR testing. However, in practice, members have told us that testing is extremely limited and difficult to access in many communities (limited to Emergency Departments), and employers discourage testing or even encourage working without a testing if symptoms are mild.

Average PCR testing rates per million population, Jan. 31, 2020 to Apr. 5, 2022

Ontario	100,877
Alberta	98,220
Prince Edward Island	91,967
Canada	**75,864**
Quebec	65,038
Manitoba	56,884
Saskatchewan	54,287
Northwest Territories	40,913
Nova Scotia	40,657
British Columbia	**35,459**
New Brunswick	34,744
Newfoundland and Labrador	31,261
Yukon	30,894
Nunavut	27,745

Emerging research shows that health care workers have greater prevalence of symptoms following acute infection (Long COVID), which demonstrates the importance of maintaining access to PCR testing for health care workers as a confirmatory diagnostic test that can support clinical treatment/therapy, WorkSafeBC and LTD claims.

We urge the BC government to restore and maintain access to PCR and rapid testing and ensure that it is easily accessible and encouraged for all health care workers and the public.

Urgent action needed to address health science professional shortages

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.[8]

The pandemic review is an opportunity for government to urgently make commitments to address worsening health science professional shortages.

The health 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.

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, magnetic resonance imaging technologist (MRI), occupational therapist, cardiovascular perfusionist, physiotherapist, respiratory therapist, diagnostic medical ultrasonographer,

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

social worker, registered dietitian, speech-language pathologist, clinical pharmacist, radiation therapist, and radiation therapy service technologist.

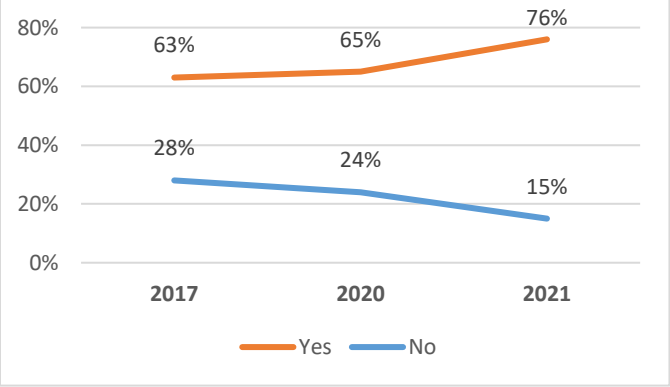
Many British Columbians have never heard of these professions, nor could they describe the critical role they play in our public health care system. Despite this lack of public awareness, health care would not function without these professionals. It is not just doctors and nurses who save lives and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

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 workload. Most concerning, 76% reported shortages in their profession, up from 63% in 2017 (see figure below). Professional shortages have reached a breaking point.

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*

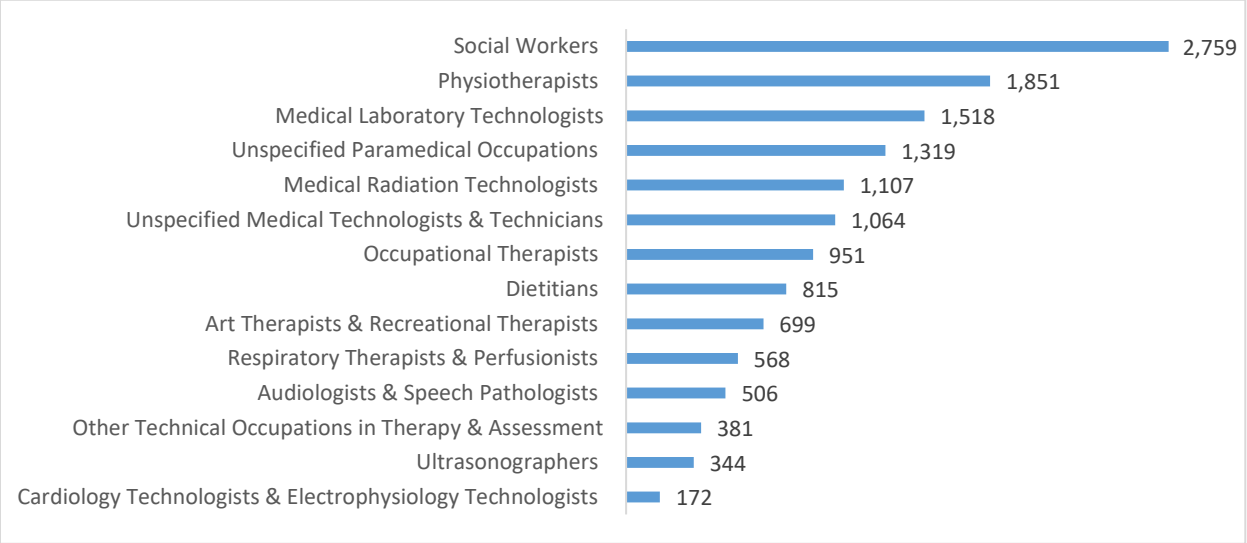
resources within existing programs in smaller communities and ensuring opportunities for British Columbians in rural, remote and Indigenous communities to train locally."

Some progress, but more government action is required

In 2019, the BC government took positive steps towards addressing health science professional 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.[9] 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.[10] These two new programs build the province's training capacity by adding to the approximately 40 students trained at BCIT.

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. Many health science professions are designated WorkBC High Opportunity Occupations, with thousands of job openings to be filled by 2029 (see figure below). The vacancies are likely to increase as demand for health care increases as a result of COVID-19.

WorkBC job openings, 2019 to 2029



[9] 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.

[10] 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.

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. Other recommendations include 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 (see table below). 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.

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 while keeping up with demand for surgeries, and diagnostic and rehabilitative services, it will depend on bold and immediate action to address these shortages.

HSA urges government to take immediate action to address worsening professional shortages through a variety of recruitment and retention strategies, including more competitive compensation and more attractive work environments.

Prevent transmission of COVID-19 to protect the health system and workforce

Delta, Omicron, and now Omicron sub-variant BA.2 reveal the necessity of both vaccination and public health measures to control disease transmission in order to preserve health services. 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.

Now in the sixth wave, each new wave of infection 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 face greater challenges the longer that COVID-19 places significant pressure on hospitals.

As the WHO, Public Health Agency of Canada, and the last two years have demonstrated, we are likely to require the strategic use of public health measures to protect our health services and workforce from being overwhelmed. BC should restore and maintain access to PCR and rapid testing, require isolation for COVID positive individuals, and continue to require masking in health care settings. These public health tools can suppress transmission and prevent infection,[11] 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;[12] 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).[13]

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

[11] 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.

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

[13] Canadian Institute for Health Information, 2021.

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.

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.

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.

Conclusion

The COVID-19 Lessons Learned Review provides an opportunity for government to improve its response to the ongoing COVID-19 pandemic. HSA hopes that government finds our submission helpful and we hope government will fully consider our concerns and recommendations.