HEALTH SCIENCES ASSOCIATION

The union delivering modern health care

Submission to the Select Standing Committee on Finance and Government Services

Budget 2019 Consultation

October 2018

Introduction

The Health Sciences Association of BC (HSA) is a union that represents more than 18,000 health science and social service professionals who deliver specialized services at over 250 hospitals, residential care homes, child development centres, community health and social service agencies. HSA was established in 1971 with nine health science professional disciplines at two Lower Mainland hospitals. Today, HSA members, working in over 60 disciplines, provide critical health care and social services that support the health and well-being of British Columbians.[1] HSA is also the leading union in the child development sector, representing almost 1,000 members at more than 15 agencies across the province.

Traditionally, health care was just a doctor assisted by a nurse, but today, successful delivery of care depends on a multidisciplinary team approach involving many professionals working together. Patients who are dealing with a chronic disease, acute illness or serious injury may receive care from several different health science professionals in their journey to recovery and rehabilitation.

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

HSA appreciates the opportunity to provide recommendations to the Select Standing Committee on Finance and Government Services as part of the Budget 2019 Consultation. We thank the Committee for considering the perspectives of frontline health science and social service professionals who are committed to improving health and social services for everyone.

Budget 2019 Context

British Columbia has the fiscal capacity to make bold investments in our public health care system that will improve the health of British Columbians by improving the effectiveness of health services over the long-term.

Based on the First Quarterly Budget Update, the 2017/18 fiscal year ended with $301 million in surplus. The updated three-year fiscal plan (2018/19 to 2020/21) is projected to include significant surpluses, especially in the first two years of the plan. In the health sector, spending is projected to increase by 5.4 per cent from 2017/18 to 2018/19, 5.0 per cent from 2018/19 to 2019/20, and 3.6 per cent from 2019/20 to 2020/21.[2] Despite annual increases, it is important that we examine our province's capacity for public spending, represented by program spending as a share of our Gross Domestic Product (GDP). In 2011/12, health spending as a share of GDP was 7.8 per cent but by 2017/18 this had fallen to 7.5 per

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

[2] Ministry of Finance (2018, Sep.), *2018/19 First Quarterly Report*, Table A7, 59.

cent.[3] Over the course of the updated three-year fiscal plan, health spending as a share of GDP is projected to fall from 7.4 per cent (2018/19) to 7.3 per cent (2020/21). This tells us that our health spending is not keeping pace with our growing population, economy, or our fiscal capacity to increase spending. Health sector capital expenditures are projected to total $3.48 billion over three years. The taxpayer-supported debt to GDP ratio is forecast to remain below 16 per cent and taxpayer-supported capital spending will remain below 2 per cent of GDP over the three-year plan. BC is in a very good position to make bold capital investments.

Budget 2018 took critical steps to address the social deficit that has emerged in our province over the last decade and half. Across the board, social program spending, including health care, has not kept pace with growing service demands nor has past funding reflected our province's growing fiscal capacity. Budget 2019 is an opportunity to continue to reinvest in BC's public health care system and build a strong foundation that will improve the health and wellbeing of all British Columbians in communities across the province. It is important to provide adequate funding for prevention-oriented health care and social services, including early childhood intervention services, as prevention increases health equity and makes more cost-effective use of health care resources by reducing the use of acute and emergency services. Making upstream investments in preventative health and social care is smart public policy and makes good economic sense.[4] [5] These investments can increase economic growth and tax revenues by reducing productivity losses resulting from physical and mental illness,[6] while also reducing costs to the public health care system that result from poverty and health inequalities.[7]

HSA was very pleased with the investments made in Budget 2018, and our submission makes recommendations on how to refine these funding commitments and more effectively target those dollars and implement long-lasting service improvements.

1. Health human resources planning: Address shortages of health science professionals

For health system improvement and current reform efforts to be successful, it is critical that there is immediate action to address shortages and recruitment and retention challenges facing health science professionals. In BC, the majority of current and future priority professions that have "labour market challenges that require provincial attention and monitoring", as indicated in the 2018 *BC Provincial Health Workforce Strategy*, are health science professions (see Appendix B).

[3] Ministry of Finance (2018, Sep.), *2018/19 First Quarterly Report*, Table A8, p. 60.

[4] M. Cohen (2014), *How Can We Create a Cost-Effective System of Primary and Community Care Built Around Interdisciplinary Teams?* Submission to the Select Standing Committee on Health, Canadian Centre for Policy Alternatives—BC Office.

[5] Conference Board of Canada (2013), *Improving Primary Care Through Collaboration: Briefing 3—Measuring the Missed Opportunities*.

[6] Mental Health Commission of Canada (2016), *Making the Case for Investing in Mental Health in Canada*.

[7] I. Ivanova (2011), *The Cost of Poverty in BC*, Canadian Centre for Policy Alternatives—BC Office

The lack of health human resources planning in our province has created acute challenges across the public health care system, and negatively affects timely access to medically necessary care for patients. For example, a persistent shortage of sonographers in the public system causes delays in patients receiving an ultrasound and, in some cases, diagnosis beyond what is clinically recommended.[8] A greater focus on workforce planning and development would seek to identify the reasons for these challenges, and develop proactive solutions to these problems, rather than the current approach, which can be described as ad-hoc and crisis-driven.

HSA is encouraged that the Ministry of Health acknowledges these challenges, and is working to address them. In early 2018, the Ministry of Health released a high-level provincial health human resources strategy to guide future action. In addition, thanks to a Ministry of Health contribution, a $3 million professional development fund was announced in September 2018 for health science professionals working under the Health Science Professionals Bargaining Association collective agreement.

However, the lack of staffing within the Ministry of Health to focus on health science professionals will unfortunately limit progress in the complex area of health human resources planning, where each discipline often faces its own distinct challenges. This requires focused attention on the distinct challenges facing the over 60 different health science disciplines. The provincial government's promising and ambitious new directions in primary care, surgical and diagnostic services, mental health and addictions care, and seniors' care, will require health human resources planning and actions to focus on the entire health care team, and cannot be limited to one or two professions, such as nursing and medicine where the greatest focus remains.

HSA believes that establishing a *Health Science Professions Policy Secretariat*, similar to the existing Nursing Policy Secretariat, is necessary to help the Ministry of Health and other ministries make concrete progress on workforce challenges facing health science professionals, which are the second-largest health professional group with the greatest number of distinct disciplines. A *Health Science Professions Policy Secretariat* would ensure focused and ongoing attention at a senior Ministry of Health-level on policy and practice issues.

Unlike physicians and nurses, health science professionals do not have specific representation or voice at senior-level policy and decision-making tables at the Ministry of Health or health authorities. Rather, the Chief Nurse Executive currently carries that responsibility. There is no question that the lack of health science professionals reflected in clinical leadership and senior policy roles contributes to the acute recruitment and retention challenges in rural and urban communities across BC. A *Health Science Professions Policy Secretariat* would modernize BC's approach to health workforce planning and align BC with emerging best practice internationally. Senior-level policy secretariats for the health science professions have been established in Australia, England, and Scotland.

[8] C. E. Harnett (2016, Sep. 22), Backlog of 18,000 ultrasounds halts bookings for routine tests, *Times Colonist.*

Recommendations

1.1 Establish a *Health Science Professions Policy Secretariat* to support and develop health science professionals who face some of the greatest workforce challenges.
1.2 Increase Ministry of Advanced Education funding to support the expansion of additional training capacity for current priority health science professions[9] identified by the Ministry of Health in its 2018 *BC Provincial Health Workforce Strategy*, including public practice physiotherapists, occupational therapists, speech language pathologists, sonographers, MRI technologists, and perfusionists.

2. Community Health Centres: Improve access to multidisciplinary primary care and mental health services

Budget 2018 provided new funding for team-based primary health care and mental health and addictions services. This included $150 million for multidisciplinary primary care teams, and $290 million for improved mental health and substance use (MHSU) services (supported by federal dollars). This funding is a welcome investment in improving comprehensive primary health care that integrates MHSU services.

BC is embarking on significant primary care reform, with a focus on several primary care models, including Urgent Primary Care Centres, Community Health Centres (CHCs), and Primary Care Networks[10] (PCNs). CHCs are distinct from the other models of primary care because they are non-profit organizations that bring together health care and social services under one roof, including the provision of multidisciplinary team-based primary care, mental health services (e.g. clinical counselling), social services and supports (e.g. housing and income support worker), and often deliver public health functions that reflect community needs. CHCs are noted for their multidisciplinary teams, the integration of health care and social services, providing care to vulnerable groups who may lack access to regular primary care, and a commitment to addressing the social determinants of health through advocacy and community development.[11]

To date, Urgent Primary Care Centres and Primary Care Networks are the furthest ahead in terms of implementation, in part because these new models have secured Ministry of Health funding. CHC expansion is part of the BC government's new primary care strategy announced in May 2018,[12] and although CHC policy development and implementation planning is underway in the Ministry of Health, there is no separate and dedicated funding stream for the CHC sector.

[9] "Priority" professions are defined in the Provincial Health Workforce Strategy as "having labour market challenges that require provincial attention and monitoring."

[10] PCNs are geographical groupings of multiple Patient Medical Homes.

[11] BC Association of Community Health Centres (2017), *Community Health Centres: Advancing Primary Health Care to Improve the Health and Wellbeing of British Columbians*.

[12] Office of the Premier (2018, May 24), BC government's primary health-care strategy focuses on faster, team-based care, press release.

Recommendation

2.1 As part of provincial primary care reforms, the Ministry of Health should establish a separate and dedicated Community Health Centre funding stream to ensure the expansion of Community Health Centres province-wide.

3. Child Development Centres: Improve access to early intervention services for children with disabilities

Child Development Centres (CDCs) provide therapy and services to more than 15,000 children and youth and their families. CDCs serve children with physical, behavioural, neurological and developmental disabilities, including cerebral palsy, Down syndrome, autism, fetal alcohol spectrum disorder, and other mental health and behavioural issues. CDCs provide early intervention services for children with disabilities from birth to age six, enabling these children to participate in school and in their communities. Early intervention includes speech and language services to help develop the ability to communicate, physiotherapy to improve mobility and coordination, and occupational therapy to enable these children to manage a variety of daily living activities that come naturally to able-bodied children. Early intervention also includes Infant Development Consultants during the first three years of a child's life who help parents develop the many skills needed to care for a child with a disability. Supported Child Development Consultants work with child care centres and preschools so that children with disabilities are able to participate in these programs.

Most early intervention funding is provided by the Ministry of Children and Family Development (MCFD) through the Children and Youth with Special Needs (CYSN) funding stream, which includes Early Intervention Therapies, Infant Development, Supported Child Development and School Age Therapies. Budget 2018 introduced BC's first social program in a generation – universal child care – and HSA welcomes this new program. Although the new child care plans state that funding will ensure that child care is accessible to children with disabilities, it does not appear that new funding is flowing to Children and Youth with Special Needs funded programs, including Child Development Centres, to increase staffing for therapists necessary to reduce long wait times for children with disabilities.

Put simply, the lack of funding for early intervention therapists and supported child development consultants means that CDCs have long waits for children and families trying to access services. In one northern CDC, for example, there are nearly 250 children on the waitlist trying to access early intervention therapies, and as a result, children are going to school without ever receiving assessments. As the BC Association for Child Development and Intervention has noted, and based on the input from CDCs across the province, the Early Intervention Therapies program continues to receive very little new funding, despite new investments in the broader sector and the fact that wait times are often longest in this area.

There is an urgent need to increase funding to CDCs, and especially for early intervention therapists. There are simply not enough clinicians to ensure that children with disabilities have access to publicly funded early intervention therapy. MCFD funding agreements should also account for increases in negotiated collective agreements, which ensure that CDC clinician compensation rates are consistent with the health sector, and that CDCs can recruit and retain staff.

Recommendations

3.1 Increase access to early childhood intervention services by increasing MCFD funding for pediatric therapists in Child Development Centres, including occupational therapists, physiotherapists, speech language pathologists, and behavioural therapists.
3.2 Increase funding for supported child development services, so that children with special needs will have equitable access to newly funded child care spaces.
3.3 Provide sustained funding lifts to unionized child development centres, in line with negotiated collective agreements, in order to ensure Child Development Centres can provide high-quality services and can recruit and retain pediatric therapists and child development professionals.

4. Fund provincial health-system Improvement Teams

As BC moves forward with ambitious and promising health care reforms, one of the most critical aspects to success is the ability to appropriately resource health system improvement efforts. In BC, we continue to have a problem with one-off pilot projects and initiatives that are not coordinated at the provincial level or even across a single health authority. As a result, attempts at system improvement tend to be limited in scope, are not entrenched over the long term, and often lack buy-in from frontline clinicians because changes were implemented in a top-down, hierarchical manner. The March 2018 provincial surgical and diagnostic strategy is a welcome shift in policy direction; however, for it to be successful, it will require learning from high-performing health systems and using international best practices, including *Improvement Teams*.

Improvement Teams would be Ministry of Health-coordinated teams supporting system improvements, which would be deployed across priority areas, including timely access to surgical and diagnostic services and developing multidisciplinary primary care teams. Improvement Teams would play a critical role in promoting and entrenching effective local innovations system-wide. More specifically, Improvement Teams would be established at the local level within health authorities and focused on a particular service delivery (e.g. Surgical Access), and supported with technical and strategic assistance from the Ministry of Health and BC Patient Safety and Quality Council. As a specific example based on the new provincial surgical strategy, Improvement Teams could be used to implement the centralized booking system and "First Available Surgeon" model within each health authority to facilitate faster access to surgical consultations, pre-surgical supports, and surgery.

Over 20 years ago, Scotland faced many of the same challenges as BC does today in terms of waits for elective surgeries and diagnostic services. After over 15 years of deploying Improvement Teams to

facilitate system redesign and improvement initiatives, Scotland has made tremendous progress improving timely access to surgical and diagnostic services.[13] The key to success is deploying hands-on technical and strategic supports to local clinical and administrative teams to help them implement improvements, and to do it in a way that improvements are coordinated across the health system.

Improvement Teams should support frontline clinician-champions, and would be coordinated by the Ministry of Health, and include representation from BC Patient Safety and Quality Council improvement advisors, health authority sponsors, and frontline providers. Improvement Teams are not about creating additional management, but are intended to change how existing organizations' administrative staff work with, and support, their frontline clinicians to lead local change based on a provincial framework. To be effective, Improvement Teams would likely second frontline clinicians who have been involved in system improvement initiatives, so that they spread the lessons and improvements with other local teams of providers in other health authorities. Specific lessons and recommendations of how BC could design and deploy Improvement Teams is well documented.[14]

Recommendation

4.1 Create Improvement Teams provincially to work with local providers to spread system-wide best practices.

5. Health Sector Capital Funding

The September 2018 First Quarterly Update includes $3.48 billion of health sector capital funding over three years. This is a significant investment in maintaining and updating the capital infrastructure necessary to deliver quality public health care, including hospitals, mental health and addictions services, and seniors' residential care. Since 2011/12 the average annual rate of health sector capital spending change has been 5 per cent; however, from year to year, capital spending has varied considerably.[15] For example between 2012/13 to 2013/14, spending fell by 7 per cent and between 2018/19 to 2019/20, it is projected to fall by 18 per cent.[16] 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 health sector capital infrastructure.

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[13] A. Longhurst, M. Cohen, and M. McGregor (2016), *Reducing Surgical Wait Times: The Case for Public Innovation and Provincial Leadership*, Canadian Centre for Policy Alternatives—BC Office, pp. 27-28.

[14] A. Longhurst et al. (2016, pp. 41-43); NHS Scotland and Institute for Healthcare Improvement (2018), *The Scottish Improvement Journey: A Nationwide Approach to Improvement*, NHS Scotland; Institute for Healthcare Improvement (n.d.), Science of Improvement: Forming the Team; Institute for Healthcare Improvement (n.d.), Improvement Team Roles and Responsibilities.

[15] Ministry of Finance (2018), *2018/19 First Quarterly Report*, Table A10, p. 62.

[16] Analysis of budget figures from Ministry of Finance (2018, p. 62).

Unfortunately, due to the use of public-private partnerships (P3s) over the last 16 years, 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."[17] Put simply, P3s are not fiscally prudent and do not deliver good value for money because they inflate the costs to taxpayers. We applaud the BC government's decision to align with the growing body of evidence by pursuing the Royal Columbian Hospital redevelopment as a publicly delivered design-build project.[18] We urge all future capital infrastructure to be delivered through more cost-effective traditional procurement.

Seniors' long-term residential care: In particular, we urge bold capital investments in the seniors' long-term residential care sector. A significant share of BC's health authority and non-profit-owned residential care homes are older and will require replacement. We also know from a large body of empirical health services research that staffing levels and mix are key predictors of care quality and resident outcomes. The weight of the BC and international evidence demonstrates that health authority and non-profit-owned care homes provide generally superior care to care provided in facilities owned by for-profit companies.[19]

Table 1: Direct Care Hours in Publicly Funded Residential Care Facilities by Ownership Type[20]

Ownership Type	Average of 2015/16 funded allied health hours (hours per resident per day)	Average of 2015/16 funded direct care hours (nursing + allied) (hours per resident per day)
Health Authorities (public)	0.34	3.28
Non-Profit Organizations	0.30	3.01
For-Profit Businesses	0.30	2.96

In BC, health authority-owned residential care homes have, on average, the highest levels of direct care, including nursing and "allied health" (which include health science professionals such as occupational therapists, physiotherapists, dietitians and social workers) (see above table). Public health authorities and non-profits are closer to meeting the provincial guideline of 3.36 hours of direct resident care per day.

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

[18] N. Eagland (2018, Sep. 22), Dix reveals Phase 2 of Royal Columbian Project will be a design-build, *The Vancouver Sun*. See also: K. Reynolds (2018, Jan. 25), As UK Auditor disparages P3s, BC continues to use them, Canadian Centre for Policy Alternatives—BC Office; K. Reynolds (2017, Aug. 3), The enormous cost of public-private partnerships, Canadian Centre for Policy Alternatives—BC Office.

[19] A. Longhurst (2017), *Privatization and Declining Access to BC Seniors' Care: A Urgent Call for Policy Change*, Canadian Centre for Policy Alternatives—BC Office, pp. 12-13; M. J. McGregor and L. Ronald (2011), *Residential Long-Term Care for Canadian Seniors: Non-Profit, For-Profit or Does It Matter?* IRPP.

[20] Analysis of Office of the Seniors Advocate (2017), *Residential Care Facilities Quick Facts Directory*.

Despite a body of evidence indicating that, on average, BC's publicly owned care homes perform better than other ownership types,[21] the share of public and non-profit-owned residential care beds in BC has fallen 10 percentage points between 2001 and 2016, and beds in the for-profit sector are increasing at a faster rate.[22] This tells us that we need to see greater capital investments in non-profit and especially health authority owned residential care facilities where care quality is superior.

Recommendations

5.1 Continue to make bold investments in maintaining and expanding our health sector capital infrastructure using more cost-effective traditional procurement approaches, including health authority-owned seniors' residential care.

5.2 End the use of public-private partnerships (shown to deliver poor value for money to taxpayers) and disband and cease funding to Partnerships BC (the agency that administers P3s).

6. Invest in labour policies and government capacity to ensure fairness and economic security for workers

Over the last 16 years, changes to BC labour policies and cuts to the Employment Standards Branch have created a significant degree of economic insecurity for workers. Between 2000 and 2016, cuts to the Employment Standards Branch amounted to a 50 per cent reduction in enforcement staff despite a 23 per cent in total employment and 25 per cent increase in total number of workplaces.[23] This has opened the door to employer exploitation and abuse of precarious and vulnerable workers. Employer violations of the Employment Standards Act and the lack of proactive Branch enforcement have been extensively documented.[24] The Employment Standards Act – the minimum legal protections for non-unionized workers – has not been modernized in 25 years, and the number of Branch enforcement officers should increase from pre-2001 levels to reflect the larger number of workers.

In addition, insufficient funding for the Labour Relations Board has deprived workers and employers of labour justice in numerous ways, including operational challenges that create barriers to the Board carrying out its mandate.

[21] Office of the Seniors Advocate (2018), *From Residential Care to Hospital: An Emerging Pattern*.

[22] Longhurst, 2018. In 2001, non-profit and health authority-owned beds made up 76 per cent of total beds, which fell to 66 per cent in 2016. Publicly funded beds owned and operated by private companies increased from 24 to 34 per cent over this period.

[23] BC Employment Standards Coalition (2017), *Workers' Stories of Exploitation and Abuse: Why Employment Standards Need to Change*, p. 53.

[24] BC Employment Standards Coalition (2017), *Workers' Stories of Exploitation and Abuse: Why Employment Standards Need to Change*.

Recommendations

6.1 Substantially increase the Employment Standards Branch budget to ensure that it can shift to a proactive enforcement approach. This will allow for the elimination of the "self-help kit" and enable workers to take their complaints directly to the Branch for investigation.

6.2 Restore balance and fairness to the Labour Relations Code and Labour Relations Board by increasing funding to ensure that the Board has increased staffing capacity to carry out its mandate in a timely and improved manner consistent with the specific recommendations of the BC Federation of Labour.

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 the research evidence and the frontline knowledge of our 18,000 health science and social service professional members. Highly trained HSA members across rural and urban BC want to deliver the best care possible but resource constraints and staffing shortages create barriers to patient access to comprehensive, team-based care.

BC is a prosperous province and has the fiscal capacity to make significant investments in health and social care services. HSA's recommendations will move BC towards a more integrated, multidisciplinary and prevention-focused system that will improve the health and well-being of British Columbians and make the most effective use of public funding.

Appendix A

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

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

Appendix B: Ministry of Health Workforce Priority Professions[25]

Strategic Priority Areas	Current Priority Professions for 2018/2019	Future Priority Professions
I. Primary Care Services	Nurse practitioner	Registered Nurse
	Family physician	Psychologist[26]
	Licensed Practical Nurse (LPN)	Social worker
	Occupational therapist (OT)	
	Physiotherapist	
II. Adults with Complex Medical Conditions and /or Frailty	Health care assistant (HCA)	Registered Nurse
	Licensed Practical Nurse (LPN)	Rehabilitation assistant
	Occupational therapist (OT)	Dietitian
	Physiotherapist	Social worker
		Medical specialist
III. Surgical and Diagnostic Services[27]	Nurse (LPN and RN)	Anesthesiologist and GP anesthesiologist
	Nurse practitioner	Anesthesia Assistant
	Physiotherapist	Case manager
	Perfusionist	Surgeon & GP with enhanced surgical skills
		Dietitian/nutritionist
		Counsellor
		Home nursing support
		Surgical services team
		Clinical surgical subspecialists
IV. Mental Health and Substance Use	Psychiatrist	Psychologist
	RN in Mental Health (Specialty Nurse) [Registered Psychiatric Nurse RPN]	Social worker
	Occupational therapist (OT)	Clinical counsellor
	Family physician	Trained peer support
	Nurse practitioner	Pharmacist
	Physiotherapist	Nutritionist [dietitian]
		Naturopathic medicine
		Recreation therapist
		Music and art therapists
		Spiritual services
		Traditional Chinese medicine and acupuncturist
		Cross-cultural liaison
		Vocational expert
		Expert in public health
		Expert in psychosocial rehabilitation

[25] Priority professions from Ministry of Health's *British Columbia Provincial Health Workforce Strategy, 2018/19 – 2020/21*.
[26] Highlighted professions are health science professions.
[27] Although not identified in the Ministry of Health's Provincial Workforce Strategy as a priority professions, we recommend Speech-Language Pathologists and MRI Technologists be added to the current priority health science professions based on the provincial government's recently announced surgical and diagnostic strategy (which requires increasing public MRI capacity) and the shortage of public-practice SLPs identified by employers, unions, families and disability advocates and affirmed in Recommendation 20 of the BC Legislature's Select Standing Committee on Finance and Government Services' Report on the Budget 2018 Consultation.

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