HEALTH SCIENCES ASSOCIATION

The union delivering modern health care hsabc.org

Submission to the Select Standing Committee on Finance and Government Services

Budget 2021 Consultation

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A Message from Val Avery, President

This is a challenging moment globally.

Here in BC our members have been on the frontlines of the effort to flatten the COVID-19 curve. While others are told to stay home – our members head to work, day after day, putting others first to ensure the health care and social services people need are there for them.

The work our members do is often invisible, but this pandemic has shone a bright light on their important contributions. Respiratory therapists, medical laboratory and imaging technologists, dietitians, pharmacists, physiotherapists, and many others. It's not just doctors and nurses that save lives. It is the whole team of professionals.

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

Because of our commitment to public health care, BC is meeting the challenge of this pandemic head on. The response from the Provincial Health Officer and the government has been swift and effective. We applaud that. And we encourage this Committee to see this result as motivation to commit to deeper investment in our public health care system. We know – and this pandemic has reinforced this – that public health care provides better quality care and is more effective than private options.

This is the moment to ensure our system is as robust and resilient as possible – able to recover from this pandemic and to be prepared for future crises.

On behalf of the Health Sciences Association of BC's 18,000 members across the province, I respectfully submit our union's recommendations to the Select Standing Committee on Finance and Government Services for the Budget 2021 Consultation.

Sincerely,

Val Avery

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, long-term 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 non-profit agencies across the province.

Our members are dedicated to better access, better outcomes, and more comprehensive, team-based care in an integrated public system that benefits all British Columbians. HSA is a member-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 2021 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 2021: Historic economic challenges and health care pressures call for bold solutions

British Columbia faces the greatest fiscal and economic challenges since the Great Depression. The COVID-19 pandemic has also exposed the pre-existing vulnerabilities, gaps, and pressures facing public health care and social services. Only four months ago, Budget 2020 was released under very different fiscal and economic circumstances. In making this submission, we first want to acknowledge that we are putting forward recommendations without the benefit of an updated fiscal and economic update to reflect our current reality. However, despite a very different context from four months ago, we begin with a review of key revenue and spending indicators.

Fiscal outlook

Budget 2020 projected operating spending to decline as a share of GDP over the three-year plan (from 18.9% to 18.5% of GDP) after increasing to 19.2% of GDP in 2019/20.[2] This is a useful measure as it tells us whether BC's program spending is increasing (or maintaining). Looking at this over a longer time horizon, operating spending as a share of the economy is expected to decline slightly by an annual average

[1] Health science and social service professional disciplines represented by HSA are listed in Appendix A.
[2] Ministry of Finance (2020), Budget and Fiscal Plan 2020/21 – 2022/23, p. 143.

of -0.6% between 2013/14 and 2022/23.[3] In order to avoid a deep recession, it will be necessary for operating spending to significantly increase relative to GDP in Budget 2021.

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

> Think of post-pandemic rebuilding like a modern Marshall Plan (replicating the enormous, government-funded effort to rebuild Western Europe after the Second World War). We'll need a similar commitment to all-round reconstruction. We will need equally massive fiscal injections. And we will need a similar willingness to use tools of direct economic management and regulation – including public service, public ownership and planning – to make it all happen.[4]

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

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

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

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

BC debt remains very manageable, even with significant new borrowing for capital infrastructure announced in Budget 2020. The debt-to-GDP ratio, a key measure used by international credit rating agencies, remains a very manageable 14.6% in 2019/20 and is expected to increase to 17.1% in 2022/23. There is plenty of room for much bigger capital investments in Budget 2021 as a foundational part of economic recovery. Building new public-sector capital infrastructure through public financing has never

[3] Ibid.
[4] Jim Stanford, We're going to need a Marshall Plan to rebuild after COVID-19, *Policy Options*, Institute for Research on Public Policy, April 2, 2020.

been cheaper for government. HSA urges bold investments in public and non-profit infrastructure, including health care (including seniors' care), child care and child development sectors, and affordable housing.

Over the last three budgets, the provincial government has taken critical steps to address the deep social deficit that emerged in our province over the last two decades. This deficit continues to impact the lives of British Columbians today—and the pandemic has shone a light on this.

HSA applauds the provincial government's proactive approach to improving living and working conditions, healthcare, and education and training for British Columbians. Budget 2021 is an opportunity to continue to reinvest in BC's public health care system and to build a strong foundation that will improve the health and wellbeing of all British Columbians in communities across the province.

It is equally important to adequately fund prevention-oriented health care and social services, including early childhood intervention therapies, 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.[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 2020. We encourage government to build on this foundation and make significant new investments in health care and social services that will be necessary to foster a stronger, more resilient British Columbia.

[5] Conference Board of Canada (2013), Improving Primary Care through Collaboration: Briefing 3—Measuring the Missed Opportunities, Ottawa: Conference Board of Canada; Marcy Cohen (2014*), How Can We Create a Cost-Effective System of Primary and Community Care Built Around Interdisciplinary Teams?* Vancouver: Canadian Centre for Policy Alternatives.
[6] Mental Health Commission of Canada (2016), Making the Case for Investing in Mental Health in Canada.
[7] Iglika Ivanova (2011), *The Cost of Poverty in BC*, Vancouver: Canadian Centre for Policy Alternatives.

1. Address the shortage of health science professionals necessary to reduce health care wait times

COVID-19 adds pressures to an already-stretched system

For years, British Columbia has struggled with public-sector shortages of health science professionals, including 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]

In a recent survey of our members, the most concerning response was that over 42% are considering leaving public practice due to unmanageable workload.

The BC Ministry of Health's Provincial Health Workforce Strategy, 2018/19 – 2020/21 indicates that the majority of current and future priority professions with labour market challenges that require provincial attention and monitoring are health science professions (see Appendix B). Because of unfilled vacancies and low staffing levels, many departments rely on overtime to deliver necessary services. One therapy department in an acute care hospital, for example, can only manage demand using upwards of *1,800 to 2,000 hours of overtime each month* – and yet they have vacancies that have remained unfilled for a year. This is not a sustainable strategy in the immediate, medium, or long term – either economically or in terms of human resources. It is expensive and causes burnout of the limited professionals we have.

The current shortages in these fields are already taking a toll. In a recent survey of our members, 65% reported shortages in their professions, and 53% said their department already has a patient waitlist. Most concerning, over 42% told us they are considering leaving public practice due to unmanageable workload. If our public health care system is to be successful in fighting COVID-19 and working down the surgical and diagnostic backlog, it will depend on immediate action to address these professional shortages.

Fortunately, over the last three years, we have seen more efforts to address these challenges than in the previous 15 years combined. 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

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

[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

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.

The BC government has continued to build its workforce planning expertise through the creation of the new Director of Allied Health Workforce Development role in the Ministry of Health. We applaud the Ministry for making progress in the complex area of health human resource planning and attending to the recruitment and retention challenges facing more than 60 different health science disciplines. These developments demonstrate serious commitment to addressing public-sector health science professional shortages.

Faster surgery, better recovery: Tackling the COVID-19 surgery and diagnostic testing backlog through improved public funding and service delivery

COVID-19 has created the largest surgery and diagnostic testing backlog in BC history. As BC resumes scheduled procedures with an ambitious plan to ramp up public sector volumes of diagnostic testing and surgeries,[11] it will be critical that our public system has the health science professionals in place necessary to ensure that we can work down the backlog as quickly as possible while also reducing wait times over the long term.

Over the last decade and a half, the BC government allowed the largest for-profit, private-pay medical imaging and surgical industry in the country to emerge, despite operating in violation of the Canada Health Act.[12] BC has also come to rely on contracting out publicly funded procedures to for-profit clinics. Based on a national survey conducted in 2017, 34 out of 136 for-profit facilities were based in BC. The report found that "user charges are overt, with clinic staff in Nova Scotia, Alberta, British Columbia, Saskatchewan and Quebec stating outright that they are private clinics and patients are required to pay."[13] Thirty out of 34 of these facilities in BC reportedly charged unlawful user fees, contrary to the Canada Health Act. In fact, among all provinces, BC has had the greatest dollar-for-dollar clawbacks in the Canada Health Transfer—16 years in a row—because it has allowed illegal patient user fees to persist.[14] British Columbia also had the greatest number of for-profit MRI clinics (14) of any province.[15] A large body of

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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.

[11] Ministry of Health, Province launches renewal plan for surgeries, May 7, 2020.

[12] Kathy Tomlinson, Some doctors charging both government and patients privately in illegal double-dipping practice, *The Globe and Mail*, June 10, 2017.

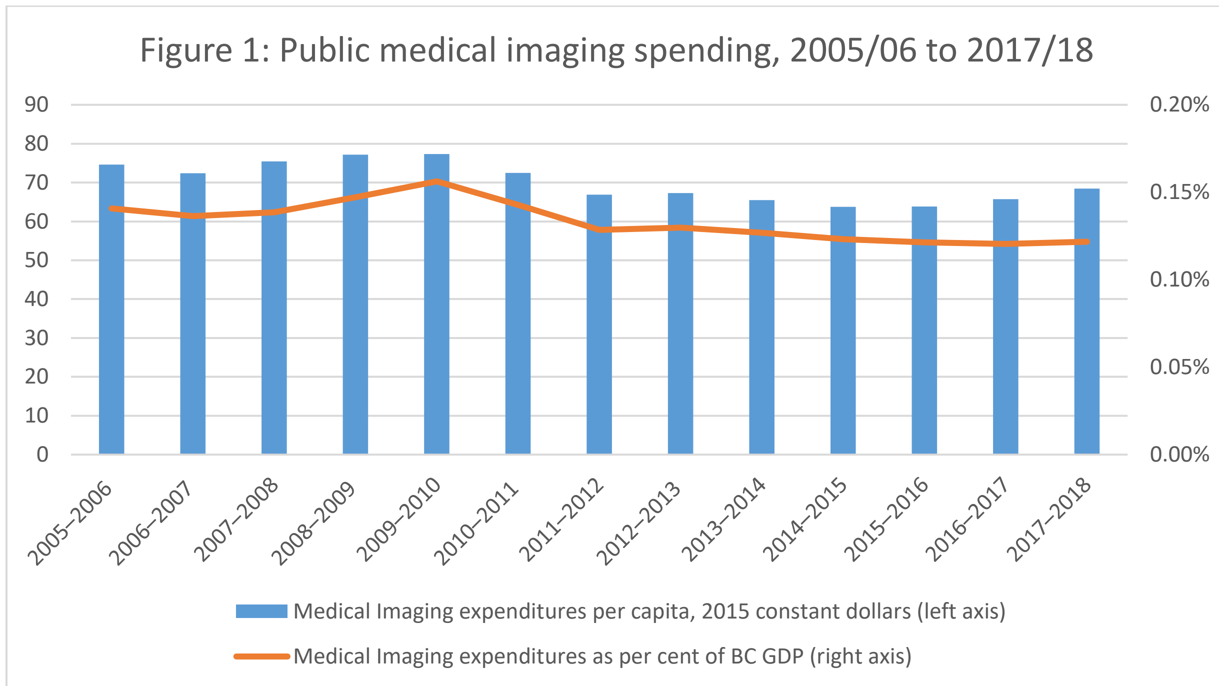
[13] Ontario Health Coalition (2017), *Private Clinics and the Threat to Public Medicare in Canada*, Toronto: OHC, p. 10.

[14] Michael Mui, BC fined for medical extra-billing 16 years in a row, *StarMetro Vancouver*, April 12, 2018.

[15] Ontario Health Coalition (2017), p. 8.

evidence clearly demonstrates that neither private financing nor private delivery of surgical and diagnostic services reduce public waiting times or ensure equitable access.[16]

At the same time there has been growth in private-pay medical imaging, public funding for medical imaging declined in BC. Real per capita spending fell from a peak of $77 in 2009/10 to $64 in 2014/15 (Figure 1). This decline suggests reduced *public* investment in medical imaging at a time of marked growth in the for-profit imaging facilities where patients must pay out-of-pocket. Because of shortages, this contributes directly to longer wait times for those who must rely on publicly funded imaging.



Source: Canadian Institute for Health Information (CIHI), Trends in Hospital Expenditure, 2005–2006 to 2017–2018 — Data Tables — Series B: Hospital Expenditure by Functional Area; CIHI National Health Expenditure Trends, Appendices A, B, D.

Over the last three years, BC has made important progress cracking down on illegal extra-billing in health care and increasing timely access to publicly funded and delivered surgeries and medical imaging. By 2017/18, real per capita public spending on medical imaging was on the rise and spending as a share of BC GDP had stabilized. We welcome this development.

In 2018, the BC government announced its Surgical and Diagnostic Strategy, with a commitment to addressing BC's low public MRI volumes, which had been significantly below other provinces and contributed to the growth of private-pay imaging in for-profit facilities. The BC government acquired two

[16] Vanessa Brcic (2015), Evidence is in: privately funded health care doesn't reduce wait times, *Policy Note*, Vancouver: Canadian Centre for Policy Alternatives; Andrew Longhurst et al. (2016), *Reducing Surgical Wait Times: The Case for Public Innovation and Provincial Leadership*, Vancouver: Canadian Centre for Policy Alternatives, pp. 17-22; Stephen Duckett (2020), Commentary: The consequences of private involvement in health care – the Australian experience, *Healthcare Quarterly 15*(4), pp. 21-25.

for-profit MRI clinics and made significant investments in expanding MRI capacity in hospitals.[17] This involves running 10 machines 24 hours a day, seven days a week – up from one machine prior to the implementation of the surgical and diagnostic strategy.[18] In the Vancouver region in 2018, health authorities implemented central intake for MRI referrals thereby introducing a proven public innovation that streamlines the referral process and reduce waits. And by 2019, the BC government had successfully reduced wait times for MRI scans in all health regions.[19] We are pleased to see additional public MRI capacity coming online, most recently with the first-ever MRI machine at Ridge Meadows Hospital in Maple Ridge.[20]

The COVID-19 surgery and diagnostic testing backlog brings even greater urgency to increasing public-sector capacity and implementing proven wait-time solutions in the public system.

The COVID-19 surgery and diagnostic testing backlog brings even greater urgency to increasing public sector capacity and implementing proven wait-time solutions in the public system. BC still lacks an explicit prohibition against private-pay imaging facilities, which will put BC at risk for further Canada Health Transfer deductions and undermine efforts to reduce public wait times.

The growth of for-profit, private-pay medical imaging clinics pulls limited imaging technologists from the public system, making it more difficult to increase hours and volumes in public hospitals. It is no surprise that MRI technologists are in short supply in the public system, with health authorities reporting that evening and weekend shifts are difficult to fill. In order to work down the diagnostic testing and surgical backlog as quickly as possible, and maximize public hospital hours, it will be critical to ensure that for-profit diagnostic and surgical facilities are not undermining these efforts. In Saskatchewan, for example, where the government has been explicitly violating the Canada Health Act and encouraging private-pay MRI tests (thereby pulling a limited pool or professionals out of the public system), the public MRI waiting list doubled between 2015 and 2019.[21]

We applaud the BC government for moving over the last three years to increase funding and delivery of surgeries and diagnostic tests in the public system; we are in a much better place today than had this work never been initiated. However, we hope to see further efforts to prohibit and enforce private-pay diagnostic imaging and surgeries, and instead, focus exclusively on increasing public funding and delivery in order to reduce the COVID-19 backlog and reduce waits over the long-term.

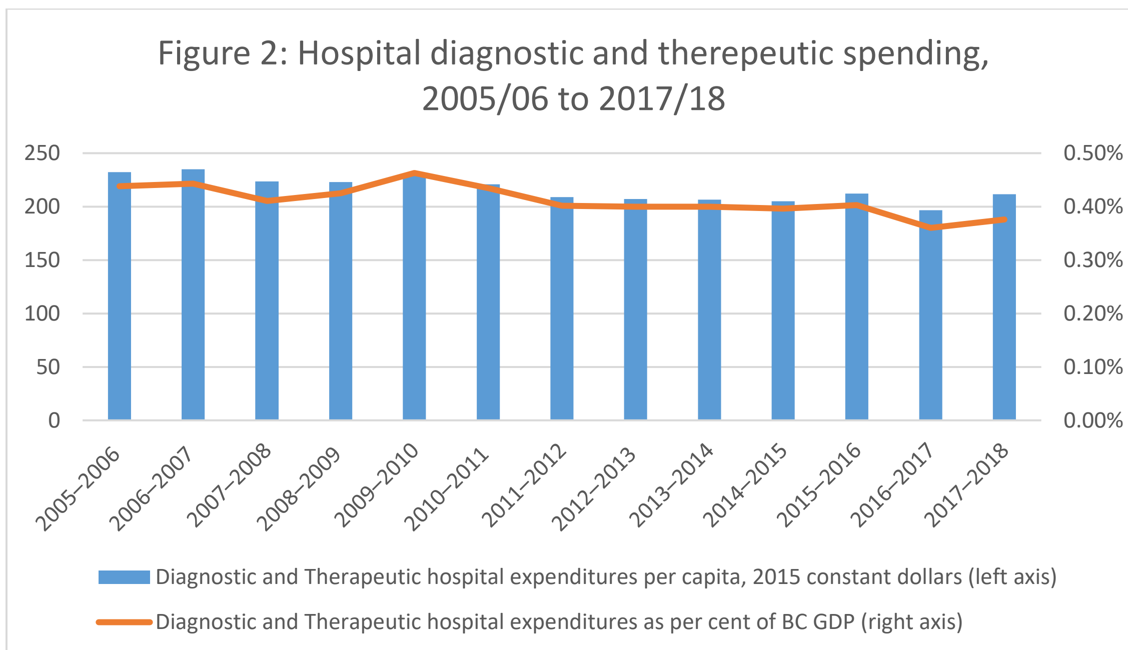
The BC government is on the right track increasing hospital hours to perform more surgeries and diagnostic testing, but as the evidence indicates, it must be accompanied by system improvements. Increasing surgical volumes, without addressing the inefficiencies of current processes (e.g., managing waitlists, referral processes, patient care pathways), risks workforce burnout and delaying working down

[17] The Canadian Press, BC's MRI strategy 'dramatically' exceeding target, minister says, *CBC News*, May 2, 2019.
[18] Ricahard Zussman, BC government slashes wait times for MRI procedures, *Global News*, May 8, 2019.
[19] Ibid.
[20] Roxanne Hooper, MRI arrives at Maple Ridge hospital this week, *Maple Ridge-Pitt Meadows News*, June, 4, 2020.
[21] Adam Hunter, Sask. MRI model putting federal dollars at risk, NDP says, *CBC News*, March 4, 2020.

the surgical backlog. The COVID-19 backlog demands bold steps to make pre-surgical, perioperative, and post-surgery system improvements standard practice provincially.[22] These public innovations, including administrative efficiencies by moving waitlists from individual surgeons' offices to centralized health authority waitlists, have been shown to effectively reduce public wait times.

Specifically, we encourage expanding the five provincial hip/knee programs (announced 2018) as comprehensive, team-based rapid access orthopedic clinics province-wide with pre-surgical assessment and triage by physiotherapists and occupational therapists, and therapeutic supports for non-surgical patients and optimizing surgical patients (i.e., PT, OT, and nutrition supports). In a recent *Canadian Medical Association Journal* commentary responding to the COVID-19 backlog, Dr. David Urbach (Chief of Surgery, Women's College Hospital, Toronto) and Dr. Danielle Martin (Executive Vice-President and Chief Medical Executive, Women's College Hospital) make the case that central intake, pooled referrals, and team-based care pathways (often referred collectively as "single-entry models") are an "efficient, fair, and ethical approach to addressing pent-up demand for surgery in the presence of constrained resources."[23]

In order to expand team-based rapid access orthopedic clinics, delivered by health authorities, funding will need to be increased for the diagnostic and therapeutic professionals necessary for these team-based models to be effective, reduce wait times, and make the health system more cost-effective over the long term. This will require increasing hospital spending on diagnostic and therapeutic services, which has fallen on a real per capita basis from $235 in 2006/07 to $211 in 2017/18 (Figure 2).



Source: Canadian Institute for Health Information (CIHI), Trends in Hospital Expenditure, 2005–2006 to 2017–2018 — Data Tables — Series B: Hospital Expenditure by Functional Area; CIHI National Health Expenditure Trends, Appendices A, B, D.

[22] Andrew Longhurst, Marcy Cohen, & Margaret McGregor (2016), *Reducing Surgical Wait Times: The Case for Public Innovation and Provincial Leadership*, Vancouver: Canadian Centre for Policy Alternatives; David Urbach and Danielle Martin (2020), Confronting the COVID-19 surgery crisis: Time for transformational change, *CMAJ 192*(21): E585-6.

[23] Urbach and Martin, 2020, p. 1.

Making these evidence-based models standard practice provincially will depend on addressing the shortages of public-sector health science professionals and making multidisciplinary care models standard practice.

In order to increase the number of surgeries and diagnostic testing required to work down the COVID-19 backlog, the provincial government will be required to implement a suite of measures to fill unfilled vacancies of health science professionals and increase staffing levels to address the heavy workloads that are a barrier to public-sector recruitment and retention. Specific measures to address the shortages include more clinical leadership opportunities, increased post-secondary training opportunities, incentives to attract graduates and those in private practice into public practice, and competitive wages with other provinces and the private sector.

RECOMMENDATIONS

1.1 Implement targeted recruitment and retention measures in order to address the public-sector shortage of health science professionals, including more clinical leadership opportunities, increased post-secondary training opportunities, incentives to attract graduates and those in private practice into public practice, and competitive wages with other provinces and the private sector.
1.2 Build on the success of the BC government's surgical and diagnostic wait-time strategy, by maximizing and optimizing public-sector surgical and diagnostic testing capacity rather than contracting out publicly funded procedures to for-profit facilities.
1.3 Prohibit for-profit medical imaging and surgical facilities from charging patients privately for medically necessary care in contravention of the Canada Health Act. This practice pulls limited health human resources from the public system and increases public wait times.
1.4 Optimize, and make standard practice provincially, the five Hip and Knee Programs (announced in 2018) as more comprehensive team-based rapid access orthopedic clinics for all potential surgery candidates.
1.5 Scale-up pre-surgical, perioperative, and post-surgery public innovations that have been shown, based on experiences in BC and internationally, to effectively reduce public wait times, including streamlining waitlists by moving them from individual surgeons' offices to centralized health authority waitlists and giving patients more choice to see the first available and appropriate surgeon.
1.6 Continue to expand and support the activities of the Director of Allied Health Workforce Development in the Ministry of Health.
1.7 Increase Ministry of Advanced Education funding to train more health science professionals that face public-sector shortages, including: physiotherapists, occupational therapists, speech-language pathologists, diagnostic medical sonographers, MRI technologists, medical laboratory technologists, and perfusionists.

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

The COVID-19 pandemic has clearly demonstrated the considerable risks that health care and social service workers face day after day. COVID-19 has demonstrated the urgency and necessity of strengthening occupational health and safety measures for health science and social service professionals. WorkSafeBC claims data provide a snapshot of the effects of COVID-19 on frontline staff. Since the beginning of the pandemic until June 17, there were 597 claims—the majority (358) from health care and social services sectors.[24]

Job safety critical to addressing recruitment and retention issues amidst COVID-19

Job satisfaction for the purposes of recruitment and retention in the health care sector is based to a large degree on a worker's knowledge of the hazards they may encounter in their jobs, and on their understanding that adequate measures are in place to keep them healthy and safe. Further, the evidence shows that a methodical integration of health and safety best practices with day to day job functions helps create and sustain a culture of safety, encouraging worker engagement and feelings of self worth.

Developing and maintaining a true culture of safety requires attention in a number of areas, including:

- education and training: ensuring that best practices for dealing with typical workplace hazards are identified and explored;
- ongoing workplace hazard orientation: best practices for hazard identification and risk mitigation should be shared and practiced as needed and on a regular basis;
- workplace practices: best practices should be put into practical operation in coordination with other workplace stakeholders, including supervisors, other team members and joint occupational health and safety committees; and,
- empowerment: workers must be supported in their right to know about hazards associated with their work and in their right to participate in measures to control those hazards.

The Canadian Centre for Occupational Health and Safety (CCOHS) points out that a Job Safety Analysis (JSA), accompanied by written work procedures, "can form the basis for regular contact between supervisors and workers" and can "serve as a teaching aid for initial job training."[25] According to the CCOHS, "safety and health awareness is raised, communication between workers and supervisors is improved, and acceptance of safe work procedures is promoted."

A properly designed JSA approach is intended to expand all workplace encounters and discussions about job functions and duties to include physical and psychological health and safety considerations. This is an

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[24] WorkSafeBC, COVID-19 claims data by industry, June 17, 2020.
[25] Canadian Centre for Occupational Health and Safety, Job Safety Analysis, Government of Canada, December 1, 2016 (last updated).

important step towards multi-stakeholder participation in health and safety, the expansion of a safety culture philosophy and in providing workers with the knowledge that they are valued and protected.

In response to COVID-19 and the need to redouble our recruitment and retention efforts, we recommend that a Job Safety Analysis approach be used for all health science priority professions where there are public-sector recruitment and retention challenges.

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

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

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

COVID-19 makes presumptive coverage for the whole health care and social services team even more urgent.

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.

Other provinces have extended presumptive coverage to include a diversity of health science professionals, not just nurses and health care aides. For example, since 2016, the Workers Compensation Board of Manitoba does not limit PTSD presumption to a specific occupation.

RECOMMENDATIONS

2.1 Develop a Job Safety Analysis to integrate health and safety principles and best practices into the tasks associated with each health science profession currently facing recruitment and retention challenges, by identifying potential job-related hazards, both physical and psychological.
2.2 Expand presumptive coverage to include all health care and community social service professionals under the *Workers Compensation Act* Mental Disorder Presumption Regulation.

3. Community Health Centres: A proven model to increase access to multidisciplinary primary care and mental health services

In May 2018, the BC government released its primary care strategy.[26] BC continues to advance primary care reforms with a focus on Urgent Primary Care Centres (UPCCs), Primary Care Networks (PCNs), and Community Health Centres (CHCs). We welcome the new PCNs and UPCCs established in communities across the province. For too long, access to team-based primary care has been a challenge in urban, rural, and remote British Columbia. We applaud the government for making primary care a policy priority.

CHCs are distinct from other primary care models 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 and outreach workers), and social supports (e.g. housing 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 communities who may lack access to regular primary care (including recent immigrants and newcomers), and a commitment to addressing the social determinants of health through advocacy and community development.[27]

As part of the government's primary care strategy, in 2018, the Ministry of Health consulted with a diversity of stakeholders, including health care providers, BC Health Coalition, BC Association of Community Health Centres, immigrant and newcomer-serving organizations, and the Rural Health Network.[28] Participants emphasized the value of CHCs and key opportunities to expand this proven model in BC. However, to date, CHC implementation has been slow, with only one net-new CHC opening since 2018.[29] HSA looks forward to working with the government to continue implementation of this effective team-based primary care model.

RECOMMENDATION

3.1 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.

[26] Office of the Premier, BC government's primary health-care strategy focuses on faster, team-based care, May 24, 2018.
[27] BC Association of Community Health Centres (2017), *Community Health Centres: Advancing Primary Health Care to Improve the Health and Wellbeing of British Columbians*, Vancouver: BCACHC.
[28] Longhurst, A. and M. Cohen (2019), *The Importance of Community Health Centres in BC's Primary Care Reforms: What the Research Tells Us*, Vancouver: Canadian Centre for Policy Alternatives.
[29] Ministry of Health, New community health centre coming to southeast Vancouver, Jan. 8, 2020.

4. Child Development Centres: Improve access to early intervention therapies, autism services, and early-years mental health supports

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

Early Intervention Therapies program needs significant funding boost

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

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

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

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

- In the North region, the average wait time for speech services is 335 days.
- In the Vancouver-Coastal region, the average wait for occupational therapy is 180 days.

- In the Fraser region, the average wait time for physiotherapy is 151 days.[30]

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

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

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

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

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

Provide early years mental health services funding to CDCs

HSA applauds the $74 million in funding over three years announced in Budget 2019 for mental health and addictions services for children, youth, and young adults.[31] Budget 2019 also established the Child Opportunity Benefit,[32] which will go a long way in supporting families.

The establishment of the Foundry youth mental health care model is an important step forward in serving youth with mental health issues (ages 12-24), and we applaud the provincial government for this work. Now is the time to expand mental health services into early-years programing in order to meet the demonstrated need of very young children (ages 1-5) and their families.

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[30] BC Association for Child Development and Intervention (2019), Submission to the Select Standing Committee on Children and Youth.
[31] Ministry of Finance (2019), *Budget and Fiscal Plan 2019/20 – 2021/22*.
[32] Ibid.

Now is the time to expand mental health services into early-years programming in order to meet the demonstrated need of very young children (ages 1-5) and their families.

In June 2019, the Ministry of Mental Health and Addictions released *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia*. This important policy paper committed to "enhance and expand core programming offered in child development centres and by community-based organizations delivering a core set of early intervention services for children under the age of six."[33]

Although CDCs were identified to deliver early years mental health services, in addition to existing core services such as Early Intervention Therapies, new funding to expand services has not yet been provided. CDCs and frontline therapists are eager to provide expanded access to services essential for strong early childhood development, but more resources are needed to increase staffing levels and meet the high demand for service.

RECOMMENDATIONS

4.1 Significantly increase funding for MCFD's Early Intervention Therapy Program so that Child Development Centres can ensure timely access to critical services, including: speech-language therapy, occupational therapy and physiotherapy.
4.2 Establish an additional autism services funding model that will enable Child Development Centres to directly provide these services to families.
4.3 Provide ongoing, appropriate, funding to ensure that children and families in BC can access publicly funded early-years mental health services at their local Child Development Centre.

5. Renew and expand health and social infrastructure

Budget 2020 identified $6.4 billion in major capital spending over three years on hospitals, community health facilities, and mental health centres.[34] Health sector capital spending will increase from $1.2 billion in 2019/20 to $1.9 billion in 2020/21. 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

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[33] Ministry of Mental Health and Addictions (2019), *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British Columbia*.
[34] Ministry of Finance (2020), *Budget and Fiscal Plan 2020/21 – 2022/23*.

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."[35] P3s inflate costs to taxpayers. Building on the Provincial Government's current focus on enhancing public services and infrastructure, we urge all future capital infrastructure to be delivered through more cost-effective traditional procurement.

In particular, we urge big capital investments in order to rebuild public and non-profit seniors' care in this province. COVID-19 has shone a light on the serious shortcomings of our underfunded, fragmented, and privatized seniors' care. 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.[36]

From the BC Seniors Advocate we also learned that for-profit delivered care is less cost-effective and for-profit companies cut corners on staffing including health science professionals (Table 2). 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). Health authorities and non-profits are closer to meeting the provincial guideline of 3.36 hours of direct resident care per day. As well, from the Advocate's February 2020 report, we learned that while receiving, on average, the same level of public funding, contracted non-profit long-term care operators spend $10,000 or 24% more per year on care for each resident compared to for-profit providers. In just a one-year period (2017/18), for-profit care homes failed to deliver 207,000 funded direct care hours, whereas non-profit care homes exceeded direct care hour targets by delivering an additional 80,000 hours of direct care beyond what they were publicly funded to deliver.[37]

Table 2: Direct Care Hours in Publicly Funded Long-Term Care Homes by Ownership Type, 2015/16[38]

Ownership Type	Average funded allied health hours (hours/resident/day)	Average funded direct care hours (nursing + allied) (hours/resident/day)
Health Authority	0.34	3.28
Non-Profit Organization	0.30	3.01
For-Profit Business	0.30	2.96

[35] Keith Reynolds (2018), *Public-Private Partnerships in British Columbia: Update 2018*, Vancouver: Columbia Institute.
[36] Andrew Longhurst (2017), Privatization and Declining Access to BC Seniors' Care: A Urgent Call for Policy Change, Vancouver: Canadian Centre for Policy Alternatives; Margaret McGregor and Lisa Ronald (2011), Residential Long-Term Care for Canadian Seniors: Non-Profit, For-Profit or Does It Matter? Montreal: Institute for Research on Public Policy.
[37] Office of the Seniors Advocate (2020), *A Billion Reasons to Care*, Victoria: Office of the Seniors Advocate. For her report *A Billion Reasons to Care*, the Seniors Advocate reviewed contracts, audited financial statements, and expense reports (2017/18) for 174 contracted LTCFs in BC.
[38] Analysis of Office of the Seniors Advocate (2017), *Residential Care Facilities Quick Facts Directory*.

COVID-19 has put seniors' care staffing issues into sharp focus. The Provincial Health Officer and the BC government made the very positive move to require that most staff work only one site in order to help prevent the spread of COVID-19, and also guarantee that workers will be paid according to the master collective agreement. The single-site order is a response to the serious erosion of working conditions and low staffing levels that emerged in assisted living and long-term care over the last 20 years.[39]

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

COVID-19 tells us that we can no longer ignore the crisis in seniors' care. We applaud the BC government's significant commitment over the last three years 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 which provides higher quality care. There has never been a cheaper time for the provincial government to borrow in order to renew and expand the essential social infrastructure that British Columbians count on. With the Bank of Canada's record-low overnight rate of 0.25% and program of buying provincial bonds, it has never been cheaper to make historic investments in our province's health and social infrastructure. As *The Globe and Mail* recently put it, "At no time in history has Canada been able to borrow so much for so little."[40]

RECOMMENDATIONS

5.1 Make bold investments in maintaining and expanding our health and social infrastructure using more cost-effective traditional procurement approaches.

5.2 Develop a provincial capital plan to guide historic investments in renewed and expanded health care infrastructure, with an immediate focus on including health authority- and non-profit-owned seniors' care.

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[39] Andrew Longhurst and Kendra Strauss (2020, April 22), Time to end profit-making in seniors' care, *Policy Note*, Canadian Centre for Policy Alternatives, BC Office.

[40] The Globe and Mail Editorial Board, How is Ottawa going to pay off its COVID-19 debt? With any luck, it won't have to, *The Globe and Mail*, April 27, 2020.

6. Reduce health inequalities with a strong poverty reduction strategy

More than 557,000 British Columbians live below the poverty line – the highest poverty rate in Canada.[41] We applaud the BC government for introducing *Together BC*, the province's first-ever Poverty Reduction Strategy.[42] This new strategy includes many important features including:

- comprehensive framework with cross-ministry responsibilities and investments;
- foundation in reconciliation;
- gender-based plus analysis as a lens (GBA+), which ensures policy and practice will be evaluated by its impact on sex and gender, and also other factors including race, disability, and income; and,
- measures to reduce and prevent poverty.[43]

HSA encourages the provincial government to build on this strategy, adopting an ongoing commitment to raising the minimum wage to $15.20 an hour by June 1, 2021, with regular and predictable future increases (since approximately 40% of British Columbians living below the poverty line are currently in the workforce).[44] All exemptions from the minimum wage should also be removed so that no worker is excluded from the minimum wage.[45] We also recommend that a permanent Fair Wages Commission be established to oversee the transition from the minimum wage to a living wage with a clear timeline.

In April 2020, the provincial government provided a temporary $300 monthly increase to income assistance and disability payments (for individuals who are ineligible for the Canada Emergency Response Benefit).[46] This was the right move and we applaud the government for this increase. We encourage the BC government to make these increases permanent in order to ensure that income assistance and disability rates better reflect the economic realities of living in British Columbia today. Before the COVID-19 increase, the BC government raised disability and income assistance rates by a total of $150 per month.[47]

Making the $300 increase permanent will help meet the basic needs of British Columbians receiving assistance. However, even with the $300 increase, people on assistance will still be significantly below the poverty line which is around $2,000 in metro Vancouver, using Statistics Canada's Market Basket Measure.[48] If the $300 increase is not maintained, a single person receiving income or disability assistance

[41] Ministry of Social Development and Poverty Reduction (2019), *Together BC: British Columbia's Poverty Reduction Strategy*.
[42] Ibid.
[43] BC Poverty Reduction Coalition, BC's first-ever poverty reduction plan tracks strong start with comprehensive approach but gaps need to be filled moving forward, March 18, 2019.
[44] Ibid.
[45] BC Employment Standards Coalition (2017), *Workers' Stories of Exploitation and Abuse: Why Employment Standards Need to Change*, Vancouver: Employment Standards Coalition.
[46] Andrew MacLeod, BC gives $300 monthly boost to people on income, disability assistance, *The Tyee*, April 2, 2020.
[47] Ministry of Finance (2019), Making Life Better: Budget 2019, Budget and Fiscal Plan 2019/20-2021/22.
[48] MacLeod, 2020.

can expect $760 and $1,183, respectively, per month.[49] In Vancouver, the average cost of a one-bedroom apartment is $2,100.[50]

As the BC Poverty Reduction Coalition and many other organizations have recommended, we too encourage the provincial government to increase income assistance and disability rates to at least 75% of the official poverty line.[51] In health care and social services, our members see firsthand the economic difficulties many British Columbians face and urge the provincial government to continue to implement a strong poverty reduction strategy.

RECOMMENDATIONS

6.1 Continue to implement a strong Poverty Reduction Strategy that includes raising the minimum wage to $15.20 an hour by June 2021, with regular and predictable future increases, and remove exceptions from the minimum wage.
6.2 Create a permanent Fair Wages Commission to oversee regular and predictable minimum wage increases that transition the minimum wage to a living wage with a clear timeline.
6.3 Make the temporary $300 increase to disability and income assistance rates permanent, and continue to increase rates to at least 75% of the poverty line.

7. 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 tend to have better population health outcomes.[52] There is another benefit: eliminating health inequalities that result from poverty and income inequality, and improving population health outcomes, can result in significant cost-savings to the provincial treasury, freeing up resources that can be used, for example, to expand access to public mental health and addiction services.[53]

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[49] Government of British Columbia, BC Employment and Assistance Rates, accessed June 24, 2020.
[50] Vancouver Sun, Vancouver's Average Rental Price for One Bedroom Apartment Jumps to $2100, October 18, 2018.
[51] Iglika Ivanova and Seth Klein (2019), BC's first-ever poverty reduction strategy: An important step forward, but does it go far enough? *Policy Note*, Canadian Centre for Policy Alternatives, BC Office.
[52] R. Wilkinson and K. Pickett (2009), *The Spirit Level: Why More Equal Societies Almost Always Do Better*, London: Penguin; K. Pickett and R. Wilkinson (2015), Income inequality and health: a casual review, *Social Science & Medicine 128*, 316-326.
[53] Health Officers Council of BC (2008), *Health Inequities in British Columbia: Discussion Paper*. Eliminating public health care costs attributable to health inequalities are estimated to save the Province of BC up to 20% of current public health care expenditures.

The previous provincial 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.[54] In a 2017 analysis conducted by Alex Hemingway and Iglika Ivanova of the Canadian Centre for Policy Alternatives, they found that:

> […] tax changes since 2000 have disproportionately benefited the richest British Columbians, who have saved more both in dollar terms and as a share of their income. Households with income over $400,000—the richest one percent—won big with a tax cut of $39,000 per year on average (or 4.3% of their income), compared to what they would have paid with 2000 effective tax rates.[55]

This period of regressive tax shifts significantly reduced BC's fiscal capacity to make investments in critical social programs and climate change measures. If we dedicated the same share of GDP to public spending today as we did in 2000, we would have $7 billion more available each year.[56]

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.[57] 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%."[58]

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

In February 2020, the BC government announced a new personal income tax rate of 20.5% on taxable income over $220,000 with the new bracket retroactive to January 1, 2020 (Table 3)—a tax fairness measure expected to bring in $216 million in 2020/21.[59] However, the troubling growth of severe income and wealthy inequality in our province merits further measures to increase the progressive nature of income taxes. Coupled with these positive measures to eliminate MSP fees and introduce new personal

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[54] M. Lee, I. Ivanova and S. Klein (2011), *BC's Regressive Tax Shift: A Decade of Diminishing Tax Fairness, 2000 to 2010*, *Canadian* Centre for Policy Alternatives—BC Office.

[55] Alex Hemingway and Iglika Ivanova (2017, February 16*)*, *Tax fairness in BC? Hardly*, *Policy Note*, Canadian Centre for Policy Alternatives, BC Office.

[56] Alex Hemingway (2019, March 25), Reality check: Only BC's very richest paying higher tax rate, *Policy Note*, Canadian Centre for Policy Alternatives, BC Office.

[57] Chad Pawson, Why the most wealthy in BC are being hit with a higher income tax, *CBC News*, February 18, 2020.

[58] Alex Hemingway (2020, January 6), Happy New Year—no more MSP! *Policy Note*, Canadian Centre for Policy Alternatives, BC Office.

[59] Iglika Ivanova and Alex Hemingway (2020, February 18), Our take on Budget 2020, *Policy Note*, Canadian Centre for Policy Alternatives, BC Office. 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.

income tax brackets, we suggest the BC government build on these measures and consider introducing an additional income tax bracket for the highest-income earners.

Table 3. Personal income tax brackets and rates, 2020 tax year

Taxable Income - 2020 Brackets	Tax Rate
$0 to $41,725	5.06%
$41,725.01 to $83,451	7.70%
$83,451.01 to $95,812	10.50%
$95,812.01 to $116,344	12.29%
$116,344.01 to $157,748	14.70%
$157,748.01 to $220,000	16.80%
Over $220,000	20.5%

Source: BC Ministry of Finance

RECOMMENDATION

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

Conclusion

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

Our recommendations are based on research evidence and the frontline knowledge of our 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 comprehensive, team-based care.

COVID-19 has shone a bright light on new and pre-existing pressures. We strongly encourage bold and decisive action in order to strengthen our public health care system now and over the long term.

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

Summary of Recommendations

Health Science Professional Shortages and Public Health Care Wait Times

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

1.2 Build on the success of the BC government's surgical and diagnostic wait-time strategy, by maximizing and optimizing public-sector surgical and diagnostic testing capacity rather than contracting out publicly funded procedures to for-profit facilities.

1.3 Prohibit for-profit medical imaging and surgical facilities from charging patients privately for medically necessary care in contravention of the Canada Health Act. This practice pulls limited health human resources from the public system and increases public wait times.

1.4 Optimize, and make standard practice provincially, the five Hip and Knee Programs (announced in 2018) as more comprehensive team-based rapid access orthopedic clinics for all potential surgery candidates.

1.5 Scale-up pre-surgical, perioperative, and post-surgery public innovations that have been shown, based on experiences in BC and internationally, to effectively reduce public wait times, including streamlining waitlists by moving them from individual surgeons' offices to centralized health authority waitlists and giving patients more choice to see the first available and appropriate surgeon.

1.6 Continue to expand and support the activities of the Director of Allied Health Workforce Development in the Ministry of Health.

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

Occupational Health and Safety

2.1 Develop a Job Safety Analysis to integrate health and safety principles and best practices into the tasks associated with each health science profession currently facing recruitment and retention challenges, by identifying potential job-related hazards, both physical and psychological.

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

Community Health Centres and Primary Care

3.1 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.

Child Development Centres and Early Childhood Development

4.1 Significantly increase funding for MCFD's Early Intervention Therapy Program so that Child Development Centres can ensure timely access to critical services, including: speech-language therapy, occupational therapy and physiotherapy.

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

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

Health Care and Social Services Capital Infrastructure

5.1 Make bold investments in maintaining and expanding our health and social infrastructure using more cost-effective traditional procurement approaches.

5.2 Develop a provincial capital plan to guide historic investments in renewed and expanded health care infrastructure, with an immediate focus on including health authority- and non-profit-owned seniors' care.

Health Inequalities and Poverty Reduction

6.1 Continue to implement a strong Poverty Reduction Strategy that includes raising the minimum wage to $15.20 an hour by June 2021, with regular and predictable future increases, and remove exceptions from the minimum wage.

6.2 Create a permanent Fair Wages Commission to oversee regular and predictable minimum wage increases that transition the minimum wage to a living wage with a clear timeline.

6.3 Make the temporary $300 increase to disability and income assistance rates permanent, and continue to increase rates to at least 75% of the poverty line.

Provincial Revenues and Tax Fairness

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

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

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

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

Appendix B: Ministry of Health Priority Professions[60]

Strategic Priority Areas	Priority Professions for 2018/2019	Future Priority Professions
I. Primary Care Services	Nurse Practitioner	Registered Nurse
	Family Physician	Psychologist
	Licensed Practical Nurse (LPN)	Social Worker
	Occupational Therapist (OT)	
	Physiotherapist	
II. Adults with Complex Medical Conditions and /or Frailty	Health Care Assistant (HCA)	Registered Nurse
	Licensed Practical Nurse (LPN)	Rehabilitation Assistant
	Occupational Therapist (OT)	Dietitian
	Physiotherapist	Social Worker
		Medical Specialist
III. Surgical and Diagnostic Services[61]	Nurse (LPN and RN)	Anesthesiologist and GP Anesthesiologist
	Nurse Practitioner	Anesthesia Assistant
	Physiotherapist	Case Manager
	Perfusionist	Surgeon & GP with enhanced surgical skills
		Dietitian
		Counsellor
		Home Nursing Support
		Surgical Services Team
		Clinical Surgical Subspecialists
IV. Mental Health and Substance Use	Psychiatrist	Psychologist
	Registered Psychiatric Nurse	Social Worker
	Occupational Therapist (OT)	Clinical Counsellor
	Family Physician	Trained Peer Support
	Nurse Practitioner	Pharmacist
	Physiotherapist	Dietitian
		Naturopathic Medicine
		Recreation Therapist
		Music and Art Therapists
		Spiritual Services
		Traditional Chinese Medicine and Acupuncturist
		Cross-Cultural Liaison
		Vocational Expert
		Expert in Public Health
		Expert in Psychosocial Rehabilitation

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

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

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 Deepers
	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