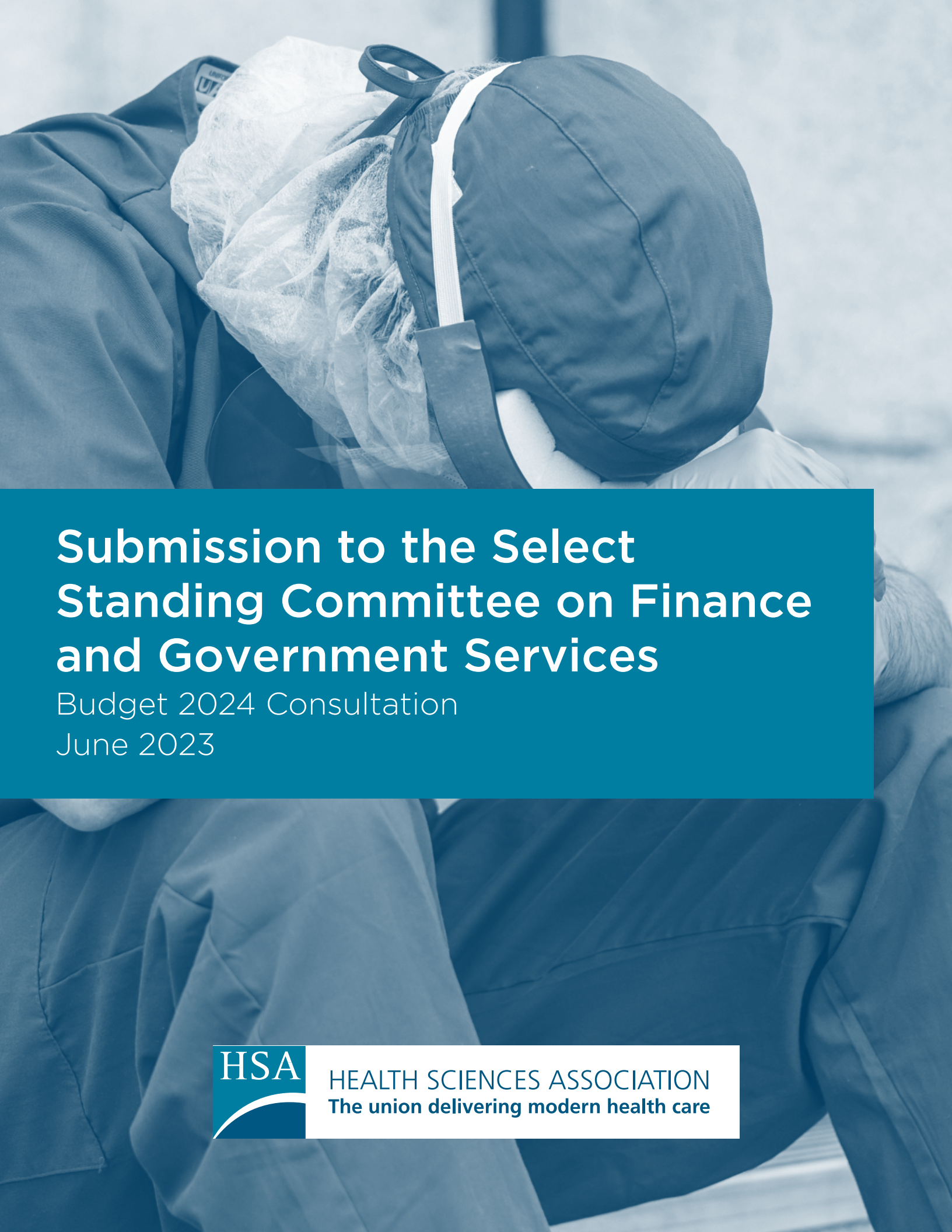


Submission to the Select Standing Committee on Finance and Government Services

Budget 2024 Consultation

June 2023

HSA

HEALTH SCIENCES ASSOCIATION

The union delivering modern health care

Contents

Message from HSA President Kane Tse

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

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

Our health care system is seeing alarming health human resources shortages: anesthesia assistants, medical radiation technologists, radiation therapists, medical laboratory technologists, pharmacists, PET technologists, physiotherapists, and many others. It's not just doctors and nurses. It is the whole team of health care professionals.

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

BC can no longer afford to move incrementally on the growing professional shortages crisis. We need bold action in Budget 2024.

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

Kane Tse
President, Health Sciences Association of BC

Introduction

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

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

Budget 2024 context

Fiscal year 2022/23 is expected to end with a surplus of $3.6 billion. In 2023/24, a $4.2 billion deficit is forecast, followed by a $3.8 billion deficit in 2024/25, and a $3 billion deficit in 2025/26, due to lower economic growth. These deficits may sound big; however, they represent about 1% or less of the provincial economy (GDP).

Taxpayer-supported capital spending (non-public-private partnerships) on public infrastructure like hospitals, schools, and roads is planned to increase from $8.1b in 2022/23 to $11.8b in 2023/24, followed by modest increases in following years.[1] Debt remains very manageable, even with new borrowing for capital infrastructure. The debt-to-GDP ratio, a key measure used by credit rating agencies, is forecast to be 19% in 2023/24, and expected to increase to 21% in 2024/25.[2]

In May 2023, Moody's affirmed the province's triple-A credit rating. BC continues to have the highest rating across the four credit-rating agencies of all provinces.[3]

Even as the province continues to make significant investments in public services, operating expenditure as share of BC's economy continues its pre-pandemic decline. As Canadian Centre for Policy Alternatives economists note in their Budget 2023 policy note:

> *Even with the expenditures in Budget 2023, provincial operating spending as a share of GDP (the size of the provincial economy) has declined substantially from where it stood 25 years ago – part a consequence of severe social spending cuts under the previous BC Liberal government. Spending by this measure had largely levered off since the BC NDP came to power, with the exception of a temporary jump during the pandemic. […] If spending in 2023/24 returned to the levels of two decades ago (as a share of GDP), we'd have about another $5b available to invest in priority areas this year alone. A return to those levels of public investment could be funded in part by more robust taxes on high incomes, corporations, and wealthy landowners, with the dual benefits of generating revenue and reducing inequality.*[4]

1 Budget and Fiscal Plan 2023/24 to 2025/26, 5.
2 Ibid., 7.
3 Ministry of Finance, "Rating agencies affirm BC's financial plan to invest in people, communities," media release, May 23, 2023.
4 Alex Hemingway, Iglika Ivanova, and Shannon Daub, BC budget does the right thing by prioritizing investment over austerity, Policy Note, CCPA-BC, May 1, 2023.

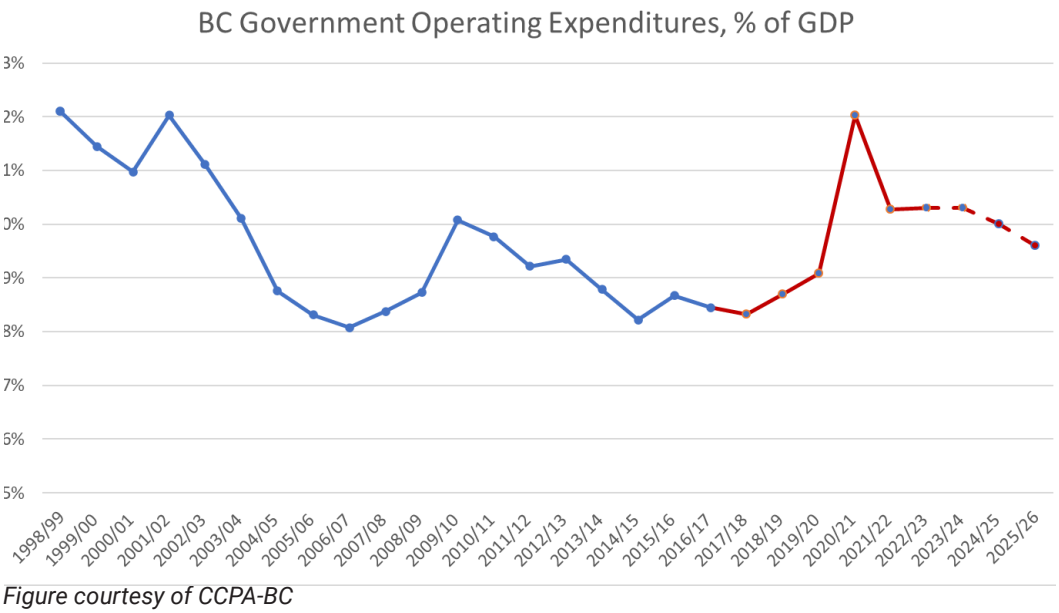


Figure courtesy of CCPA-BC

Program spending as a share of GDP is a useful measure as it tells us whether BC's program spending is increasing (or maintaining) as the economy grows, regardless of the business cycles in the economy. We should be increasing spending in line with our growing economy in order to address the magnitude of the crises we face: climate change; health workforce shortages; access to child development services and child care; lack of affordable housing; the toxic drug supply; and COVID-19.

Therefore, HSA urges continued large-scale investments in the health care and social services workforce. With the significant health care staffing shortages, now is not the time to let up on investing in the public and non-profit sectors.

Health care professionals provide critical services to BC residents. They are also foundational to the long-term resilience and economic well-being of our province, especially in rural and remote communities. Jobs in the health care and social services sector make up the second-largest share of total provincial jobs at 14 per cent (Table 1). This sector makes up the greatest share of jobs in three of seven regions, and is second-greatest in most remaining regions. The public and non-profit health care and social services sectors are key to strengthening our economy, providing family-supporting jobs, and it is these sectors that will be critical for the province's economic resilience and meeting urgent health and social needs.

Table 1: Share of total employed by industry, BC and economic regions, 2022

	British Columbia	Vancouver Island and Coast	Lower Mainland-Southwest	Thompson-Okanagan	Kootenay	Cariboo	North Coast and Nechako	Northeast
Wholesale and retail trade	16%	15%	16%	17%	15%	18%	13%	17%
Health care and social assistance	13%	18%	12%	14%	13%	18%	13%	9%
Professional, scientific and technical services	10%	8%	12%	7%	7%	4%	5%	5%
Construction	9%	10%	8%	10%	8%	8%	11%	11%
Educational services	7%	8%	7%	7%	7%	7%	5%	6%
Accommodation and food services	7%	6%	7%	7%	7%	5%	5%	8%
Manufacturing	7%	4%	7%	7%	9%	10%	8%	5%
Finance, insurance, real estate, rental and leasing	6%	5%	7%	6%	4%	3%	-	4%
Information, culture and recreation	5%	4%	6%	5%	4%	2%	5%	-
Transportation and warehousing	5%	3%	6%	3%	4%	5%	11%	6%
Public administration	5%	9%	4%	4%	5%	5%	5%	-
Other services (except public administration)	4%	3%	4%	4%	5%	4%	4%	4%
Business, building and other support services	3%	3%	3%	4%	2%	2%	-	-
Forestry, fishing, mining, quarrying, oil and gas	2%	2%	1%	3%	9%	7%	9%	16%
Agriculture	1%	1%	1%	2%	-	-	-	-
Utilities	1%	0%	1%	-	-	-	-	-

Source: Statistics Canada, Table 14-10-0392-01 Employment by industry, annual (Jan. 6, 2023 release)

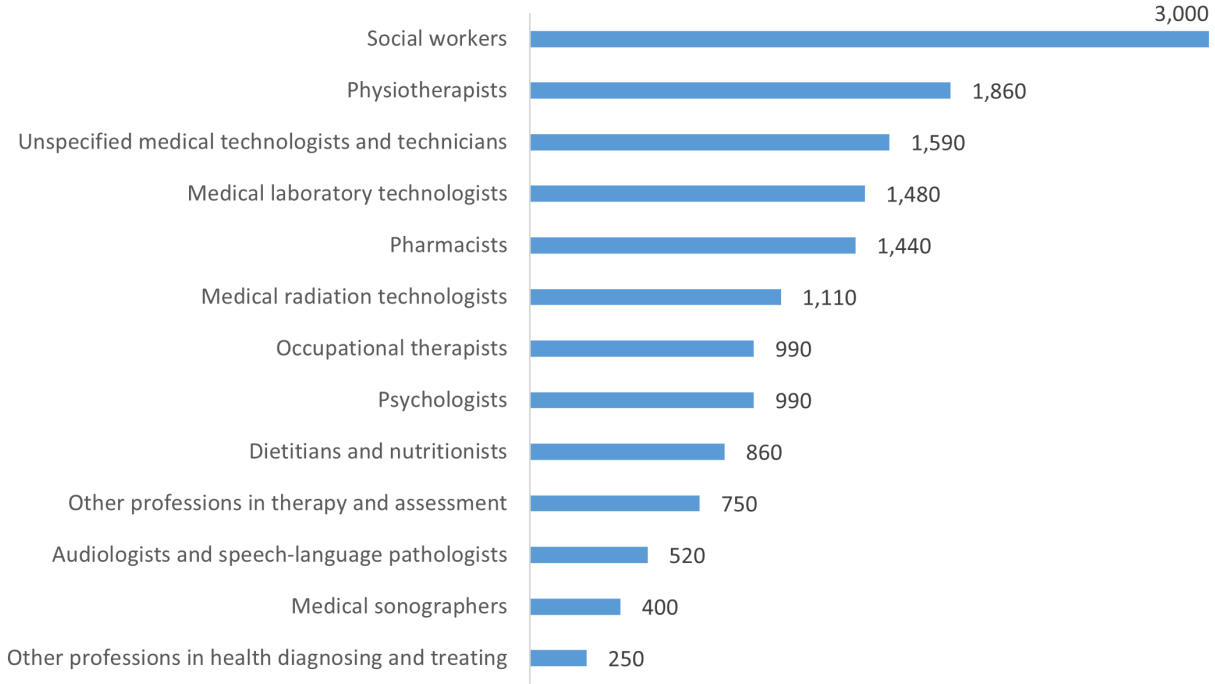
Recommendation 1: Address health science professional shortages causing long waits for diagnosis and treatment

As the BC government maintains high levels of surgical and diagnostic testing volumes, it is critical that we have the health science professionals in place, and that we are not relying on overtime and casual work to meet the demand. HSA members are exhausted and constantly working short-staffed. We simply do not have enough health science professionals to sustain the system as it currently exists.

British Columbia is struggling with extreme public-sector shortages and unfilled vacancies of medical radiation technologists, radiation therapists, PET technologists, physiotherapists, MRI technologists, sonographers, and medical laboratory technologists, among many others. These health science professions are designated WorkBC "high opportunity" professions, with thousands of job openings to be filled by 2031 (Figure 1).

The specific reasons for these shortages vary by profession, but generally arise from recruitment and retention challenges, including insufficient post-secondary training capacity, heavy workload and burnout, historically lower wages compared to other provinces and the private sector, and lack of public-sector career advancement opportunities.

Figure 1: WorkBC "high opportunity" health science professions by job openings, 2021 to 2031



The public health care system is facing dire shortages that are compromising patient care, and require immediate attention:

- Health science professionals working in chronically understaffed workplaces are burning out due to workload and excessive overtime demands, which accelerates the problem of shortages.
- Government efforts to reduce wait times for diagnosis, surgery, and therapy are jeopardized by these shortages.

- Understaffing and shortages of cancer care professionals, including radiation therapists, nuclear medicine technologists, radiological technologists (x-ray, CT, mammography), MRI technologists, medical laboratory technologists, radiation therapy service technologists, and others, is causing delays in diagnosis and has forced government to make the extraordinary decision to send cancer patients to the United States.
- BC has the fewest medical radiation technologists (or radiological technologists) per capita among the provinces, and experienced the greatest rate of decline among the provinces (-13% from 2020 to 2021). Ontario has more than double the number of medical radiation technologists per capita.[5]
- BC has the fewest medical laboratory technologists per capita among the provinces, and experienced the largest decline between 2015 and 2020.
- Other provinces are attracting BC health science professionals with historically higher wages, signing bonuses, incentives, and lower cost of living.
- The private sector is attracting physiotherapists, speech-language pathologists, and medical imaging technologists and other professionals with higher wages and more manageable caseloads.
- The ongoing privatization of post-surgery rehabilitation to for-profit clinics, especially on Vancouver Island, is luring away therapists from the public system and reducing patient access to care.
- Hospital discharges are delayed or patients go without necessary rehabilitation, leading to bed shortages, re-admissions, and widening health inequalities.

HSA has worked to address the professional shortages crisis through negotiated collective bargaining. In addition to general wage increases, HSA successfully negotiated the Recruitment and Retention Working Group that includes the bargaining association (union), employer, and government representatives. Unfortunately, employer and government representatives were unwilling to agree to jointly-developed strategies in 2020, including labour market (wage) adjustments needed to make a number of health science professions competitive with other provinces and the private sector. This delay contributed to the crisis we now face. Importantly, the new 2022-2025 HSPBA Collective Agreement, negotiated by the HSPBA and led by HSA, includes significant general and profession-specific wage increases as well as a renewal of the Recruitment and Retention Working Group and initiatives to improve workplace and cultural safety.

In 2020, the Ministry of Health and HSA identified 14 professions in need of immediate action (medical laboratory technologist, anesthesia assistant, magnetic resonance imaging technologist (MRI), occupational therapist, cardiovascular perfusionist, physiotherapist, respiratory therapist, diagnostic medical ultrasonographer, social worker (especially with a mental health and substance use focus), registered dietitian, speech-language pathologist, clinical pharmacist, radiation therapist, and radiation therapy service technologist).

Because of unfilled vacancies and low staffing levels, many departments rely on overtime and private staffing agencies to deliver necessary services. The current shortages in these fields are taking a toll. In a 2022 survey of our members, 59% said their department already has a patient waitlist and, for three years in a row, over 40% told us they are considering leaving the public sector due to unmanageable workloads. Most concerning, 83% reported shortages in their profession, up from

5 CIHI, *Health workforce in Canada*, data tables, November 24, 2022.

63% in 2017. Since this survey, shortages have worsened and unless frontline professionals see improvement, we are very concerned that more will continue to leave the public health care system.

Priority: Diagnostic imaging and cancer care professionals

Staffing shortages are worsening among diagnostic medical imaging and cancer care professions – causing long wait times for diagnosis and treatment. These professions include medical radiation technologists (X-ray, CT, mammography), MRI technologists, nuclear medicine technologists, PET technologists, radiation therapists, and radiation therapy service technologists.

Many people have not heard of these professions, but they are critical to timely diagnosis, surgery, and cancer treatment. The shortages within these professions are creating bottlenecks throughout the health care system.

In May 2023, the BC government announced that some radiation therapy patients would be offered treatment in Bellingham, Washington, in order to address unacceptably long waits for treatment in BC.

A PET technologist explains the dire situation in cancer care resulting in the shortage of health science professionals:

> *Patients need their PET scan done prior to having chemo, radiation treatment, and surgery. We often use a scan to determine where doctors should biopsy or in a situation where a biopsy is not possible. PET technologists are used to determine mid treatment or end of treatment response and surveillance imaging amongst many other things. We are also now starting PET therapies and the demand for our therapies is increasing very quickly. I'm trying to understand how we are now also supposed to staff PET therapies when we don't currently have our clinic adequately staffed for patients' PET scans.*
>
> *Out of the seven BC Cancer Agency centres in the province, all of which have radiation therapy departments, only three of the seven centres have PET. We do a large majority of the patients here in Vancouver, with 22 regular staff positions, a mix between full-time and part-time. A few of these 22 positions are currently unfilled. There's a massive and unrelenting provincewide demand for PET and yet there's only 31 of us for the entire province.*
>
> *The demand for PET is only going continue to increase in the coming years. We have absolutely no relief in sight, with the next two PET scanners (Surrey and Burnaby), being at least 10 years away. And even at that point, I can guarantee you now that there will not be staff to run those scanners. We currently can't staff our existing three PET centers and continue to struggle with staff retention.*
>
> *The only nuclear medicine program we have in BC is through BCIT and they accept a maximum of 16 students per year. However, every year, all of the nuclear medicine grad classes are finishing with substantially less than 16 grads. It's been like this for well over a decade now. These few grads are then dispersed out amongst the many nuclear medicine sites across our province and very few of them come to join us in PET.*
>
> *The demand for patients' PET scans weighs heavily on us and we feel helpless. How are we supposed to solve our staffing crisis and manage a constantly increasing demand for us while also mildly preserving our mental and physical health. There is no work-life balance anymore. We take this load home with us every day and it's no longer sustainable.*

As this PET technologist explains, the shortages are causing long delays for diagnosis and treatment, and the heavy workload is causing burnout and the loss of staff.

There are not enough post-secondary training seats in BC, and even the existing seats are not fully subscribed. For example, for the 2023 graduating class, there has been low uptake for radiation therapy, nuclear medicine, and medical radiography seats at BCIT. The medical radiation technology program has 80 seats, and only expects to graduate 27 students in 2023 – less than half. Tuition bursaries and paid practicums must be considered for these critical professions, in addition to other recruitment and retention incentives.

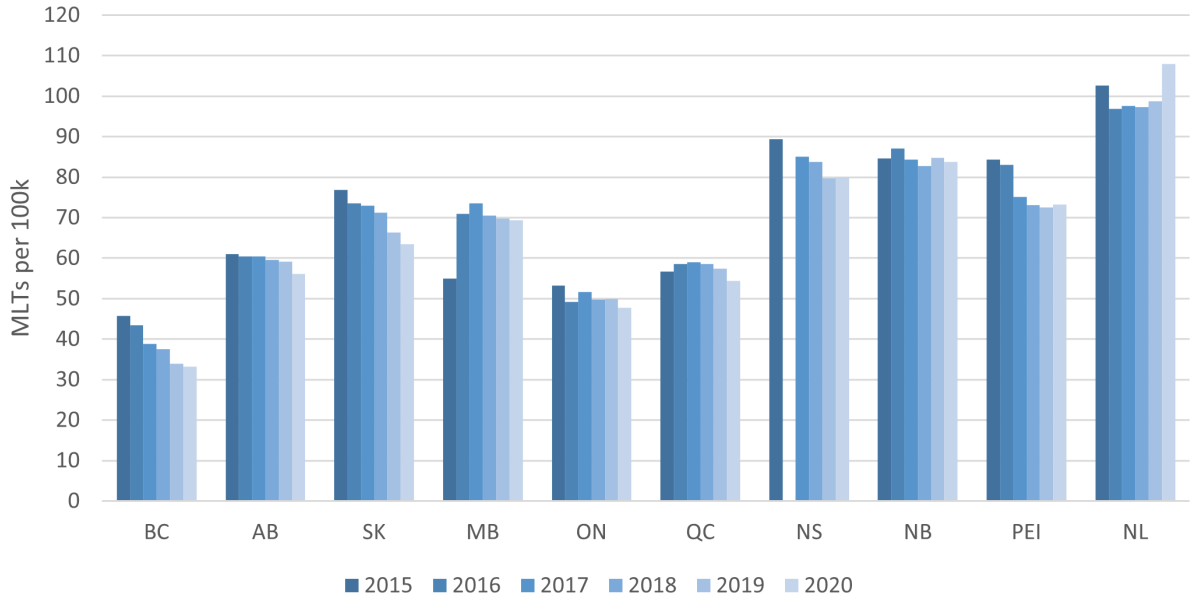
Priority: Medical laboratory technologists

It is critically important that BC have the highly trained laboratory workforce now, and in the future, that is required to provide timely diagnosis and treatment. Emergency departments rely heavily on hospital labs, and most diagnoses require these specialized professionals.

Medical laboratory technologists are skilled professionals necessary for analyzing blood and tissue samples. But due to severely low staffing levels, lack of post-secondary training seats, and historically uncompetitive wages with other provinces, BC has the lowest number of medical laboratory technologists per capita among the provinces, and has fallen the most rapidly between 2015 and 2020:

- In 2015 and 2020, BC had the fewest MLTs per 100,000 population among the provinces (Figure 2).
- In 2015, BC had 45.8 MLTs per 100k population. By 2020, this declined to 33.2 MLTs per 100k.
- BC saw the largest percentage decline (28 per cent) in MLTs per 100k among the provinces between 2015 and 2020.

Figure 2: Medical laboratory technologists per 100k population, 2015 to 2020



Source: CIHI, *Canada's Health Care Providers, 2015 to 2019 — Data Tables*, 2021.

Government initiatives are welcome, but much more action needed

Beginning in 2019, the BC government has taken positive steps towards addressing health science and allied health professional shortages:

- Forty new physiotherapy and 24 occupational therapy training seats opened between 2020 and 2022, bringing the current total to 120 physiotherapy seats and 80 occupational therapy seats.[6]
- A new diagnostic medical sonography training program opened in early 2019 at College of New Caledonia in Prince George, and a new program at Camosun College on Vancouver Island became fully operational by 2021.[7] These two new programs build the province's training capacity by adding to the approximately 40 students trained at BCIT.
- Budget 2021 provided $96 million in new funding over three years for expanded post-secondary training for nurses and health science professionals.
- In 2022, a Ministry of Health-funded BCIT bursary to support existing BCIT MRI students and HSA members complete their training was established.[8] As well, a direct-entry MRI certificate will be launched in 2023.
- In September 2022, the BC government released its health workforce strategy with a focus on retention, redesign, recruitment, and training. In February 2023, the BC budget provided $995 million to support the provincial health workforce strategy.
- In March 2023, the HSPBA negotiated improved wages for radiation therapists and radiation therapy service technologists to help ensure the success of the government's Cancer Care Action Plan.[9]
- In April 2023, the Ministry of Health provided an additional $3 million for a continuation of the professional development fund for members covered by the HSPBA collective agreement.[10] In total, $12 million has been provided.

These are important steps, and we need government to continue investing in the health science professional workforce through post-secondary training capacity, and recruitment and retention strategies.

However, increased training alone will not be enough. We must be providing competitive compensation, using recruitment and retention incentives, and providing attractive workplaces by ensuring that staffing levels permit professionals to practice how they trained and do not cause moral distress and burnout. Baseline staffing levels must increase in order to recruit into the public sector.

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

7 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.

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

9 HSPBA negotiates improved wages for cancer care specialists, news bulletin, March 30, 2023.

10 HSA achieves further funding for professional development, news bulletin, April 19, 2023.

Expand existing initiatives to shortage health science professions

Rural recruitment and retention incentives

There are a number of rural recruitment and retention incentives used in Northern Health and Interior Health and supported by the Ministry of Health, largely with a focus on nurses and physicians.

Registered nurses applying to positions in eligible communities and who make a three-year return of service commitment in NH and IH receive a $10k bonus. The bonus is available to external hires, internal casuals that do not hold permanent positions with the health authority, and requires candidates to relocate outside of their current work location/community. Ongoing, full-time employment is guaranteed by the employer.

There are many incentives for physicians, including the Rural Retention Program (RRP), which consists of a set of retention benefits paid to physicians working in eligible communities. NH began to prototype the Provincial Rural Retention Incentive (PRRI) program with the Ministry of Health's financial support.

In November 2022, IHA announced a package of incentives for specific health care professions in Grand Forks, including expansion of prototype NH programs: the PRRI and Travel Resource Program.[11] The Travel Resource Program is an internal health authority temporary staffing pool where nurses are dispatched to work in communities requiring staff.

Recruitment and retention incentives for retired and private sector professionals

For many HSPBA professions, the most significant competition is with the private sector where many professionals can earn a higher salary with reduced workload. This is especially the case for physiotherapists, occupational therapists, speech-language pathologists, dietitians, social workers, medical radiation technologists (X-ray, CT, mammography), MRI technologists, and pharmacists. In fact, BC has the second-highest number of practising physiotherapists per capita compared to other provinces, and yet the fewest working in the public sector among provinces. There are also recently retired professionals who may consider returning to public sector employment with an incentive.

Health Career Access Program (HCAP)

HCAP is a paid work and training initiative for individuals seeking an entry point to employment in health care. New hires start as a health care support worker providing non-direct care at a long-term care or assisted living site and receive paid training to become a health care aide upon successful completion of the program. HCAP trains approximately 3,000 care aides per year.

11 https://www.interiorhealth.ca/media/new-financial-incentives-launched-health-care-staff-grand-forks

RECOMMENDATIONS

R1. Address the severe shortages of public-sector health science professionals causing long waits for diagnosis and treatment.

R1.1. Expand the Interior Health and Northern Health recruitment and retention incentives to include health science professions and communities with chronic unfilled vacancies and facing service disruptions. Shortage professions include medical laboratory technologists, medical radiation technologists, nuclear medicine technologists (including PET technologists), physiotherapists, occupational therapists, diagnostic medical sonographers, pharmacists, respiratory therapists, anesthesia assistants, speech-language pathologists, MRI technologists, social workers, dietitians, radiation therapists, and radiation therapy services technologist.

R1.2. Expand the Travel Resource Program to all health science professions, beginning with priority and shortage professions.

R1.3. Create a recruitment and retention incentive for each year of service for up to five years targeting retired and private practice health science professionals who accept public sector employment under the HSPBA collective agreement. The incentive should be scaled based on accepted of part-time and casual employment.

R1.4. Replicate the Health Career Access program (HCAP) for shortage health science professions beginning with the following career pathways: medical laboratory assistant to medical laboratory technologist; respiratory therapist to anesthesia assistant; and rehab assistant to physiotherapist, occupational therapist, or speech-language pathologist.

R1.5. Review and increase baseline staffing levels for all priority/shortage health science professions as a strategy to reduce workload and burnout in order to retain existing professionals.

R2. Offer tuition bursaries and paid practicums for shortage health science professions with a return-of-service commitment to public-sector employment under the Health Science Professionals collective agreement, and pediatric therapists under the Community Health and Community Social Services collective agreements. This should be offered immediately for medical laboratory technologists, medical radiation technologists (e.g., X-ray, CT), MRI technologists, nuclear medicine technologists (including PET), radiation therapists, radiation therapy service technologists, physiotherapists, occupational therapists, and speech-language pathologists.

R3. Maximize and optimize public-sector surgical and diagnostic testing capacity rather than contracting out publicly-funded procedures to for-profit facilities, and implement evidence-based public innovations that reduce wait times.

Recommendation 2: Establish a stable funding model for non-profit Child Development Centres

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

There have been longstanding concerns about timely access to CYSN services for children and families from the Representative for Children and Youth, the legislative Select Standing Committees on Children and Youth and Finance and Government Services, as well as families, service providers, unions, and advocacy groups. In particular, the Representative and Select Standing Committee for Children and Youth expressed the need to move to a needs-based system of support that would increase access to services for children and families, and address the patchwork of services that currently exist in many communities.

In October 2021, MCFD announced specific plans to restructure CYSN services, including for those who are neurodiverse or have disabilities, by moving towards centralized service hubs called Family Connection Centres (FCCs).[12] On May 10, 2022, MCFD issued four Requests for Proposal (RFPs) for pilot sites in Kelowna, Prince Rupert, Smithers, and Terrace.

In January 2023, MCFD notified Kelowna's Starbright Child Development Centre that it was not successful in the RFP process to operate the new FCC, and that the contract would be awarded to a for-profit company that would subcontract early intervention therapies to other for-profit providers. The procurement decision would have forced closure of the sixty-year-old organization that had provided multidisciplinary early intervention therapy and supports for children and youth with autism and development needs. Families were plunged into uncertainty about the support their children need. Almost 60 highly-skilled, experienced and specialized HSA professionals – physiotherapists, occupational therapists, speech language pathologists, infant development consultants, supported child development consultants and more – faced job loss.

In response, HSA joined Starbright CDC, families, and community members to advocate for the renewal of the Centre's contract so it would continue. In February, the MCFD announced that Starbright's service contract would be renewed, and MCFD announced it would pause and re-assess the planned FCC roll-out.

While HSA is supportive of the provincial government's goals for improving delivery of service for children and youth with support needs, we do not believe a market-based RFP procurement process is appropriate for determining service providers in this highly specialized sector, where child development centres are respected non-profit organizations and have built up specialized staffing and trusted relationships with families and communities over decades.

MCFD should work collaboratively with the non-profit CDC sector, frontline staff and HSA, and families who rely on these services, to develop a stable, long-term funding model for CDCs and services for children and youth with support needs.

12 https://news.gov.bc.ca/releases/2021CFD0067-002047

Budget 2023 provides first significant increase to pediatric therapy staffing levels in over a decade

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

Extremely long waitlists for publicly funded early intervention therapies have been a problem for more than a decade. Long waits mean children do not get the care they need when they need it. The BC Association for Child Development and Intervention (BCACDI) reports that average wait times for speech-language therapy is six months, with multiple communities experiencing waits of more than 17 months. BCACDI recommends that MCFD establish a wait-time benchmark of three months. This will require standardized data collection and reporting to inform annual funding increases and resource planning. Currently there is no systematic and standardized provincial reporting.

The first significant increase to early intervention therapies was announced in February 2023. Budget 2023 makes explicit commitments to increase funding by $95 million over three years for the child development sector, including $35 million over three years to hire up to 90 new pediatric therapists, including physiotherapists, occupational therapists, and speech-language pathologists.

RECOMMENDATION

R2. Establish a stable funding model for Child Development Centres and services for children and youth with support needs (including early intervention therapies) that recognizes the critical role of the existing non-profit child development sector and supports long-term resilience and capacity building.

Recommendation 3: Increase public rehabilitative therapy staffing levels

A 2021 HSA report examined the state of public rehabilitation services for patients requiring therapy from debilitating illness, chronic disease, injury or recovering from surgery.[13]

Rehabilitative care includes physiotherapy for strength and to enable movement, occupational therapy for the skills necessary for everyday living, and speech and language therapy for communication and swallowing. Rehabilitative care provides essential therapies to foster wellness, quality of life, and optimize and maintain functional abilities.

However, the erosion and privatization of these specialized services over two decades has led to staffing shortages, a lack of services in many communities, and long wait times for patients and clients, including children and their families.

Drawing from research literature, statistical data from health authorities and the Canadian Institute for Health Information, as well interviews and focus groups with HSA members, the report found that access to public rehabilitative care is stagnant or declining in most regions when looking at public sector physiotherapist, occupational therapist, and speech-language pathologist staffing (measured as full-time equivalent) per population. For example, BC lost 89 public sector physiotherapists between 2010 and 2019. On a per capita basis, the number of physiotherapists in the public sector declined from 31 to 25 per 100,000 between 2010 and 2019.[14]

At the same time, there has been a significant expansion of privatized therapy services, especially on Vancouver Island, as health authorities outsource these essential public health care services to for-profit corporations. This draws away the very limited number of public-practice therapists into the private sector.

Therapy shortages undermine quality of care and lead to long wait times and increased length of hospital stay when patients cannot be discharged due to a lack of staffing. The erosion and privatization of public rehabilitative care and outpatient closures is the result of inadequate funding and staffing levels as demand for services grow.

RECOMMENDATION

R3. The Ministry of Health, health authorities, and Ministry of Children and Family Development should develop a provincial plan to rebuild public rehabilitative services in the province, starting immediately with expanding inpatient and outpatient services at hospitals and Child Development Centres by filling vacancies and increasing baseline staffing.

13 HSABC, HSA research examines widespread staffing shortages, erosion of public rehab care, news bulletin (October 22, 2022).

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

Recommendation 4: Prevent workplace-acquired COVID-19 with a focus on indoor air quality standards

SARS-CoV-2 variants have revealed the necessity of both vaccination and public health protections to mitigate transmission, reduce infection risk for both workers and patients, and preserve health system capacity. As the WHO, Public Health Agency of Canada, and the last three years have demonstrated, jurisdictions are likely to require the strategic use of non-pharmaceutical public health measures to protect our health system and workforce. These public health tools – including ventilation/air filtration, mask use, and testing – can suppress transmission and prevent infection.[15] These tools can help achieve the following:

- reduce strain on hospitals and the health workforce, by reducing population disease burden and staff absence;
- reduce mortality, morbidity, and severe outcomes from COVID-19, which disproportionately impact lower-income people;[16] and,
- reduce the public health care costs of hospitalization due to COVID-19 (average of $23,000 per hospital stay and more than $50,000 per ICU stay).[17]

COVID-19 continues to place significant pressure on health services,[18] as staffing shortages worsen and the elevated risks of acute and long-term complications associated with reinfection become clear. COVID-19 is a multi-system disease with increased risks of stroke, heart attack, diabetes, cardiovascular and neurological complications associated with reinfection.[19] Vaccination may reduce risk, but does not prevent severe acute outcomes or long-term complications.

Canada's Chief Scientific Advisor reports that at least 15 per cent of people infected in Canada – more than 1.4 million people – have experienced symptoms lasting at least three months, which impacts their ability to work. While there are currently no estimates of the share of the workforce affected by the post-covid condition, estimates from the US and UK are cause for concern. The Chief Scientific Advisor's Task Force on the post-covid condition recommends that governments "scale-up and monitor effective prevention interventions, such as improving ventilation in schools, long-term care homes, work and public places as a first line of prevention of SARS-CoV-2 infection and other respiratory/airborne pathogens."[20] As well, it is recommended that post-covid condition be acknowledged as real by raising awareness through outreach to citizens, schools, and workplaces.[21]

In this context, government, employers, Public Health, and WorkSafeBC all have a role to play in the implementation of evidence-based interventions to reduce transmission and infection risk for both workers and patients in health care and social service settings. As these workers are at greater risk of reinfection, especially since universal masking is no longer required, it is important that environmental measures are taken to reduce the risk of workplace-acquired COVID-19 (re)infection.

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

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

17 Canadian Institute for Health Information, 2021.

18 Xiao Xu, "New COVID modelling shows BC with the highest incidence of the virus in Canada," The Globe and Mail, May 25, 2023.

19 Benjamin Bowe, Yan Xie, & Ziyad Al-Aly, Acute and poastacute sequelae associated with SARS-CoV-2 reinfection, Nature Medicine 28(2022): 2398-2405; Penny Daflos, "BC researchers find COVID-19 infections increase risk of diabetes," CTV News Vancouver, April 21, 2023.

20 Office of the Chief Scientific Advisor of Canada, Post-COVID-19 Condition in Canada: What We Know, What We Don't Know and a Framework for Action, December 2022. The recommendation continues: "This can be achieved by improving and enforcing indoor air quality standards, such as through heating, ventilation, and air conditions (HVAC) improvements, upper room UV germicidal irradiation or other approaches." Continuous monitoring can occur through the placement and public display of carbon dioxide monitors throughout buildings, as pursued in other jurisdictions.

21 Ibid., 33.

Indoor air quality improvements and monitoring requires standard-setting at the provincial level and Joint Occupational Health and Safety Committees in each workplace. These committees, comprised of frontline workers, can provide valuable expertise when it comes to identifying higher-risk settings where monitoring shows ventilation and air filtration improvements are most needed. Professional engineers must be involved in this work as per BC's occupational health and safety legislation.

RECOMMENDATION

R4. Mitigate transmission of COVID-19 in health care and social service workplaces – and reduce the associated risks of (re)infection on frontline workers and patients – through environmental interventions including improved ventilation, air filtration, and indoor air quality standards, and ongoing monitoring.

Recommendation 5: Implement the recommendations of *In Plain Sight* report on racism in health care

On November 30, 2020, the report *In Plain Sight was* released on Indigenous-specific racism and discrimination in BC's health care system. The report includes 24 recommendations for action, all focused on addressing the ongoing experience of racism Indigenous Peoples face in the province's health care system, as described in the report:

> *Indigenous people want to see change. They want to be treated with professionalism, compassion, and respect. They want to be believed when they report health care concerns and symptoms. Participants want to see policies and actions in the health system that meaningfully address racism and discrimination, including an accessible, meaningful and safe feedback process regarding health care experiences. Indigenous people see the need for training among health care workers to counteract stereotypes.[1]*

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

HSA fully supports all recommendations of *In Plain Sight* and looks forward to regular updates from the province regarding their commitment to actioning change.

RECOMMENDATION

R5. That the BC government commit the necessary resources (budget, people, and dedicated time) in Budget 2024 to implement the *In Plain Sight* report recommendations.

Recommendation 6: 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. Reducing income inequalities through tax fairness can reduce health disparities between lower-income and higher-income groups. In fact, more equal societies have better population health.[22]

The previous government pursued massive cuts to personal and corporate income taxes of 25% and 3%, respectively. In total, between 2001 and 2010, provincial tax cuts amounted to $3.4 billion in lost revenue.[23] This period of regressive tax shifts significantly reduced BC's fiscal capacity to make investments in critical social programs and climate change measures. The Canadian Centre for Policy Alternatives calculated that if BC dedicated the same share of GDP to public spending in 2019 as in 2000, BC would have $7 billion more available each year.[24]

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.[25] In January 2020, Medical Services Premiums (MSP) — a highly regressive tax — were fully eliminated and replaced with the Employer Health Tax. In February 2020, the BC government announced a new personal income tax rate of 20.5% on taxable income over $220,000.[26] However, the troubling growth of severe income and wealthy inequality – and its effects on population health – in our province merits further action to increase the progressivity of the tax system. Building on these positive measures, HSA recommends that the BC government introduce an additional income tax bracket for the highest-income earners, which would create greater tax fairness and reduce health and income inequalities.

RECOMMENDATION

R6. Build on Budget 2020 measures to increase provincial revenues and tax fairness, by introducing an additional income bracket for the highest-income earners.

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

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

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

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

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