Commission on the Future of Health Care in Canada

Submission of the Health Sciences Association of Alberta

May 15, 2002

NOTE: HSAA's submission was discussed at the Romanow Commission's all-day "Stakeholder Round-Table" on May 15. The Round-Table was attended by President Elisabeth Ballermann and Director of Labour Relations, John Vanderkaay.

I Introduction

The Health Sciences Association of Alberta is a labour union which represents over 12,000 health care employees in Alberta. Our members work in more than 200 paramedical technical or professional disciplines and almost 70 designated support occupations.[1] HSAA has representation in each of Alberta's 17 Regional Health Authorities.

Several sister unions and advocacy organizations like the Canadian Health Coalition have already appeared before you during the Commission's 'Fact Finding Phase,' and during the current "Citizens' Dialogue Sessions." We broadly agree with their

[1] HSAA Disciplines Listed as Appendix A

positions but wish to present HSAA's own perspective and supply what we hope will be some interesting new information to the Commission.

II Underlying values

The interim report of the Commission discusses how important the values are which will inform the reform process. Health Sciences Association of Alberta unequivocally brings the following values to the table:

1. A Human Right

We consider that Medicare, as our Canadian society has elaborated it, is not, in the first instance, a set of single-payer medical insurance plans, but a right of citizenship, a human right.

Only government can guarantee human rights and citizenship rights. Ultimately, because private corporations' profit-seeking behaviors can only be regulated, and not guaranteed by government, they do not belong in the arena of direct health care provision. If health is a fundamental human right[2], then direct health care provision is

---

[2] The World Health Organization's member state Declaration of Alma Ata affirms *health* as a fundamental human right. The Declaration still rings out as an inspiration:

> *I. The Conference [on Primary Health Care] strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.*

Source: World Health Organization. *Declaration of Alma Ata: International conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978.* www.who.int/hpr/archive/docs/almaata. 2002.

intimately related. The inference may be drawn from the *Alma Ata Declaration* and other international human rights agreements that public payment and public provision of health care is a fundamental requirement to guarantee health as a human right. Medicare is the right choice for Canada.

Kevin Taft and Gillian Steward put forward the case for public provision and public payment in their small book, *Clear Answers: the Economics and Politics of For-Profit Medicine*:

> *There are sound reasons why we don't provide everything through the market place. The market has its strengths and it has its limits. If we want, health care can be opened to market forces, but costs and inefficiencies will rise, and fairness will decline. A few people will reap the benefits; the great majority will suffer the consequences. .... Attempting to strengthen our health care system by turning to private, for-profit service providers is a profound mistake.*[1]

2. The Canada Health Act

HSAA submits that the five "program criteria" of the Canada Health Act are sound. We concur with the many who state that the program criteria of: *public administration, comprehensiveness, universality, portability and accessibility*[2] are actually principles.

HSAA would also argue the merit in stretching the public administration principle to include public delivery. The Commissioner is no doubt very aware of the

struggle we and many others waged in Alberta against the Conservative Government's Bill 11. The intended sequel to Bill 11, public payment for private provision of health care service, is gathering a full head of steam in this province. Over time, we think that the consequences could be catastrophic for Medicare unless pressure from below makes the provincial government repeal this law, or we manage to end the regime at the ballot box. We will look most anxiously to the Commission's final report on how to stretch the public administration and possibly other Canada Health Act principles further into the public domain.

3. Public Service and Service to the Public

HSAA members have, like all health care workers, an ethic of public service. Since the formation of HSAA in the early 1970's, we have insisted on being paid a proper wage and having good benefits in exchange for our public service, and our service to the public. HSAA members are not entrepreneurs, and our motivation to work in our various fields is not because we are seeking riches. The endless cacophony from the Fraser Institute and organizations like it induce many people to lose track of what it is that actually motivates people to labour in the troubled public health care arena.

4. Public Nonprofit Delivery

The introduction of more for-profit delivery of health care does not produce savings for the health care system, considered as a whole, unless savings come at the expense

of our wages and benefits. Currently, labour market shortage of skilled health care workers means that private nonunionized providers are pretty well forced to pay similar wages and benefits to those that HSAA and other public sector unions have won. We do not see this situation as prevailing forever.

In the meantime we have focussed our main efforts on promoting the preservation and extension of public nonprofit delivery of the widest range of health care services.

Under prevailing labour market conditions, if they cannot take it out of wages and benefits, the private profit of contracted private providers comes from either the public purse as hidden extra payment, or from charging the consumer/patient for "extras" that the public authority will not pay for, or by cutting corners. Why is this simple relationship so hard to get across to the various previous Commissions like Mr. Mazankowski's, or Mr. Kirby's?

5. Federal Dollar Contribution to Medicare

HSAA would prefer to see a significantly more meaningful Federal Government presence in Medicare, including more shared direct funding of the provincial insurance plan. Our ideal would be the restoration of the old 50/50 formula, and

we would concur with federal NDP leader Alexa McDonough who advocated cash contribution being promptly raised to 25% and rising over time to 50%[3].

We would also concur with the Honourable Monique Begin, Professor Emeritus, who writes, “For both accountability purposes and for good governance, we should revert back to the spirit of a 50-50 cost shared arrangement, block funded by cash transfers established in multi-year blocks.”[4] Professor Begin also emphasizes that cost sharing is preferable to tax point sharing. She bluntly states that, “Tax points transfers are a taxation capacity lost forever and they carry no enforcement power whatsoever.”[5] We agree with the author of the Canada Health Act.

Clearly, rules have to be invented or restored which would inhibit if not prohibit provincial governments from reducing their expenditure for every new federal dollar which came their way. The anticipated federal dollar injection (if not lifeline) will have to be matched to provincial government dollars spent on health care services.

6. Expansion, not contraction of Medicare

The Health Sciences Association of Alberta joins with others who advocate strengthening Canadian Medicare. Leading examples of what we would like to see developed and implemented include pharmacare and fully funded home-care, including home palliative care where needed. HSAA supports the revival of the demand for publicly funded basic dental and optical care. We also support expanding Medicare to cover more long term care, all ambulance service and more evidence-based health promotion.

Regarding drugs, we have a few questions which may promote critical thinking about pharmaceuticals and Medicare. Is it out of the question that a national formulary with opted-in provincial government branches could be developed? Is it out of the question that federal patent protection legislation could be reviewed and patent protection be reduced or ended for at least the WHO [World Health Organization] list of *essential* drugs? Is it out of the question that a federally funded Pharmacare program could be developed, to begin with on a modest scale, to follow patients out of the insured Hospital services and into the home or home care or residential care? Is it out of the question that there could be Federal coverage for existing provincial pharmacare plan deductibles? HSAA notes that the Mazankowski report only touched on pharmaceutical issues. We look forward to your report filling that gap.

The provinces have, over the years, been developing and experimenting with home care programs, funded and delivered by the public sector. Private providers of home care exist everywhere, rather uneasily, beside the relatively scant services offered by public providers. In our view, the private providers should eventually be replaced with better qualified, safer and accountable public providers. However, we would like to pose a question to the Commissioner: is it political will and lack of capacity for coordination which prevents the provision of full scale public payer/public provider home care, or are there other barriers which our Association does not see?

7. Protection of public health care from “free trade”

Health Sciences Association of Alberta is concerned that existing agreements like NAFTA and pending agreements like the GATS will make health care provision vulnerable to foreign takeover. We are concerned that any “experiments” in direct public payment to private profit-driven providers - such as in Alberta’s overnight stay private hospital in Calgary, HRC - will let loose a privatization virus which will be extremely difficult to eradicate. Such experiments are being conducted in an open field, not under controlled laboratory conditions.

Not all of our citizens’ wish list could be developed right away. However, we look to the Commission to open the scope of its recommendations as far as possible. We look to the Commissioner to protect our interests and the values we hold as Canadians.

III Reporting from the Front Lines

HSAA members and the disciplines we work within are often overshadowed by analysis of what doctors and nurses are doing. Indeed, the Canadian Institute for Health Information states in their Annual Report Highlights 2001, “What we don’t know: what are the age, sex and working patterns of health care providers and managers other than physicians and nurses? How quickly is their age distribution changing?” [6] HSAA will welcome the Commission’s contributions to filling this important research gap.

From our membership database and recent bargaining survey returns from the hospital and laboratory sector, we have determined our top disciplines by population. Table 1 below lists all of the disciplines which have over 100 members represented by HSAA in paramedical technical and professional bargaining units. In May, 2002, there were 11,200 workers in the paramedical professional and technical bargaining units represented by HSAA in Alberta; the balance of our 12,000 plus dues payers are categorized as "Support." Actual totals in the field will be somewhat larger because not every health sciences employee is represented by our union. Nevertheless, our figures are more comprehensive than those obtained by the Provincial Health Authorities of Alberta (PHAA) from an employer survey[3].

Table 1 lists twenty-one disciplines. These are a mix of paramedical professional and paramedical technical classifications. The total represented is about four fifths of all paramedical technicals and professionals represented by HSAA. Discussion on 'average age' follows in the next section of this submission.

---

[3] The PHAA 2001 employer survey list includes the following hospital facility general classifications. Many of HSAA's Laboratory Technologists work in a private-public partnership company called Calgary Laboratory Services, and are not shown in the PHAA survey. HSAA's statistics for population of each occupation are more comprehensive. See Table 1, page 10.

Occupation	Employer Survey
Medical Radiation Technologists	763
Laboratory Technologists	755
Respiratory Therapists	606
Physical Therapists	571
Social Workers	412
Health Record Technicians	391
Occupational Therapists	386
Pharmacists	377
Pharmacy Technicians	364
Dietitians	316

Source: Provincial Health Authorities of Alberta. *Multi-Employer (MER)/Health Sciences Association of Alberta - Technical/Professional Bargaining*. www.phaa.com/Bargaining/HSAA. 2002.

Table 1: Number and Average Age of Paramedical Professional and Technical Employees represented by HSAA in Alberta as of April 25, 2002

Discipline	Number Represented	Average Age
Laboratory Technologist	1,538	40
Lab Assistant/Attendant/Helper	891	39
Medical Radiation Technologist	815	39
Physical Therapist	783	40
Occupational Therapist	748	36
Respiratory Therapist	628	36
Social Worker	548	44
Pharmacy Technician	442	35
Speech Lang Pathologist/Therapist	418	37
Health Record Technician	417	41
Pharmacist	376	38
Dietitian	310	38
Combined Lab & X-Ray Technician	208	35
Psychologist	208	46
Recreational Therapist	189	38
Emergency Medical Technician	159	34
Diagnostic Sonographer	145	41
Biomedical Equipment Technologist	105	42
Cardiology Technologist	102	41
Radiation Therapist	102	37
Registered Emergency Paramedic	101	41
Total / Average Age	**9,233**	**39**

Most of these occupations and more are experiencing shortages as service demand continues to grow. In addition, the private sector is bidding some paramedical professionals out of the public system.

For example, in April of this year, the Rockyview Hospital in Calgary lost three of its five ultrasound techs (Diagnostic Sonographers) to the private sector which is offering signing bonuses of up to $10,000.[7] Pharmacists working for large retailers are known to be paid twenty to thirty thousand dollars a year more than hospital pharmacists. "Just as the Liberals predicted, the burgeoning for-profit health-care sector, nourished by the Klein government, is eating into our public system," said MLA Kevin Taft on April 18, 2002.[8]

An important consideration here is that the market logic of for-profit health care drives private providers to look for the "easier cases." The less complex the case, the more profits for the owners, as a rule. Statutory limits on what private providers are able to offer have been eroded, and public payment has been afforded through contracting out of services which used to be exclusively provided by the public sector. The trend will be to push the acuity level in the public sector higher and consequently more expensive to treat. Higher acuity in the face of staff shortages translates to more stress on the job for health care workers in the public sector. In our opinion, the Government of Alberta, in particular, is creating a vicious spiral, which is the real out of control element in our medical care system, not budgets.

Greener pastures may also lure our professionals to other jurisdictions. Based on a sixty-two cent dollar, here is a chart of 2002 wage rates bargained for the Stevens Hospital by our American sister union, District 1199 Northwest in Washington state[9], compared to our current Alberta benchmark rates for selected occupational groups[10]:

Table 2: HSAA wage rates compared to US Pacific Northwest union wage rates (as of January 1, 2002)

HSAA Classification	**HSAA $ Cdn./hr Start and Top Steps**	**1199NW Using Closest Title and $ Cdn./hr Start and Top Steps**
Laboratory Technologist I	20.57 - 26.16	23.78 - 34.75
Medical Radiation Technologist III	23.76 - 29.60	29.61 - 43.27
Physical Therapist I	22.57 - 29.01	31.67 - 46.30
Occupational Therapist II	23.84 - 30.61	41.83 - 61.12
Respiratory Therapist I	22.27 - 27.65	23.78 - 34.75
Social Worker II	22.35 - 28.73	29.61 - 43.27
Pharmacy Technician	18.06 - 21.92	20.72 - 30.27
Health Record Technician II	20.57 - 26.16	20.72 - 30.27
Pharmacist II	27.61 - 35.48	42.44 - 62.02
Dietitian II	23.84 - 30.61	29.61 - 43.27

A brief perusal of this table shows that most of the unionized US Northwest start rates and all US end rates are considerably higher than HSAA rates for these classifications. The US start rate for Occupational Therapist II is an incredible 75% more than the HSAA start rate. The US end rate for Pharmacist II also is 75% more than the HSAA end rate. Suffice to say that there is considerable inducement for our paramedical professional and technicals to relocate to higher wage areas.

It is the quality of life in this country which keeps most of us here, but when the differentials are so dramatic, the greater paycheques elsewhere become a sufficient inducement for many to relocate. HSAA does not expect the Commissioner to rectify the problems with our Canadian dollar but we do expect him to help preserve our public health care system, and part of this will be promoting comparative wages.

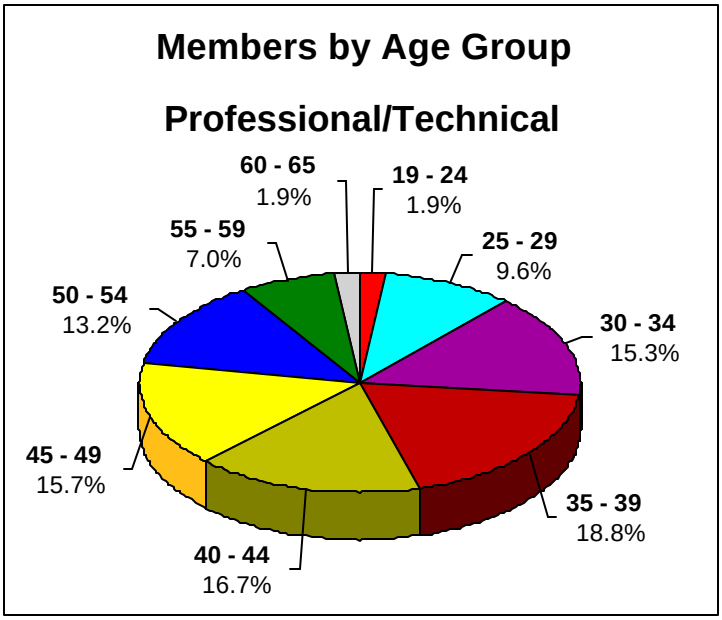
Whether interprovincial or international, HSAA does not promote poaching, especially if the home health care system is deprived of practitioners. A greater federal fiscal contribution and other forms of balancing would be welcome.

The remainder of our submission will focus on shortages and a few ideas on how the Federal Government might address these in the context of Medicare expansion and reform.

IV Addressing Shortages

Our August 2001 bargaining survey results from about a third of eight thousand members polled in Alberta hospitals revealed that half of our hospital based members are over the age of forty years. About one seventh were fifty years old or greater. Analysis of our total database shows that 54.5% of the paramedical technical and professional members of HSAA are forty years of age or greater. Graph 1 below depicts HSAA's membership age structure among the paramedical professional and technicals. Table 1 earlier showed that among the top 21 disciplines by population, the average age ranges from thirty-five to forty-six years old. Working nurses in Alberta are "forty-seven/forty-eight years of age on average,"[11] so the impending succession crisis is breathing hotter on them than us, but HSAA members are not that far behind, particulary in certain disciplines.

Graph 1: HSAA members by age group: all paramedical technical and professional bargaining units.



HSAA has identified what we call "credential creep" as a stressor on health care employee recruitment and remuneration.[4] Many occupations face increased requirements for entry to clinical practice. While less charitable analysts name this phenomenon as "credential inflation," we object to that phrase because it sounds like Fraser Institute code for "more school-less value." Furthermore, the notion of 'creep' implies that there is enough lead time to plan proper responses.

We believe that "credential creep" reflects an objective process where more highly qualified professionals are being turned out into an increasingly technologically complex world. And, the health care system is going to have to pay for these graduates.

Physical Therapy graduates from our universities will move from a minimum four year degree to an undergraduate degree plus Masters degree before entry to practice. The Michener Institute in Ontario has changed its two year program in medical radiation technology and nuclear medicine to a five year program. The specialty in Magnetic Resonance Imaging has become a 'second discipline,' requiring further post-secondary educational preparation.[12]

The emergent picture is that new graduates enter at a later age into their occupations partly because of longer training. Many will already have had a first career. We think that many new graduates will not last as long in their chosen career as planners would like to see. In fact, workplace stress combined with better wages for health care professionals and good financial planning can lead to early retirements as well.

[4] HSAA's submission to the Kirby Commission is presented as Appendix B

Finally, in a workforce in which 84% of our members are female, maternity leaves, and in some cases, obtaining part-time work for family reasons, can have a significant impact on service provision.

The combined effect of all these factors may have already resulted in a highly stressed group of veteran employees marching relentlessly toward the retirement goal posts while a younger workforce with a reduced career span follows behind.

Service demand has increased, not enough staff have been hired, and some 57% of our polled membership have issues with workload and staffing shortages. Higher stress on the job will no doubt lead to more illness, fatigue, and dissatisfaction with employment in the paramedical professional/technical work world.

In sum, shortages today will lead to crises tomorrow unless bottlenecks are removed.

Contributing to the workplace stress our members experience is the notorious stop-start boom-bust budgeting process in Alberta. Many of our members fear that layoffs are looming, because most Regional Health Authorities in Alberta did not receive the funding they say they need to meet contractual wage commitments.

Clearly, fiscal pressures have been magnified in this province as gambling revenues have largely substituted for appropriate royalty payments for our nonrenewable energy resources. The ideologically driven provincial flat tax on employment income has cost the provincial treasury much. And, as you are aware, the Government of Alberta has acted quickly on one part of the Mazankowski Report and raised the inequitable health care flat tax, known as the Alberta Health Care premium by 30% effective April 1, this year.

If we wished to be cynical, we could say that the Alberta Government is provoking a funding crisis to have a resolution presented by private sector health care providers. However, we would rather not be cynical, and hope that the Commission's final report will contain recommendations on how the Federal Government can promote and assist long term funding stability and planned growth.

More money is required. HSAA does not think that the sky is falling, and believes that extrapolations which supposedly demonstrate non-sustainability are faulty. Steven Lewis and Colleen Maxwell from the Department of Community Health Sciences at the University of Calgary show, for example, that the Mazankowski Report derives its doom and gloom scenario for cost increases from a 2000 provincial/territorial health ministers' document. These authors state that the document "was an advocacy document designed to extract as much new money as possible out of Ottawa. It presents highly selective, unbalanced, worst-case analyses and scenarios, and bases 30-plus year cost projections on extrapolations of short term trends."[13] As we stated earlier, HSAA looks forward to the Commission recommending a greater federal fiscal contribution to Medicare.

Federal labour market planning is of utmost importance in addressing shortages. Federal coordination of post-secondary training is absolutely required.

With federal oversight, there should be federal inducements. We would recommend federally funded public service full scholarships for health care careers. This could be targeted for key health care occupations which have or will have shortages. Remember that there is a European standard where post-secondary education is tuition free and bursary supported.

V Conclusion

Health Sciences Association of Alberta is a stakeholder in the health care renewal and reform process. We offer to work with the Commission. Unions like HSAA are also becoming more sophisticated, and we can supplement and may very well have, in some areas of interest, more information on our database than provincial governments, Regional Health Authorities or academic researchers.

HSAA has followed the Commission's work with great interest, and wishes the Commission and the Commissioner well in your deliberations. May the values of Canadians and the wisdom of Tommy Douglas be your guide.

Sources

[1] Taft, K. And Steward, G. *Clear Answers: the Economics and Politics of For-Profit Medicine*. p. 105. Duvall House Publishing, The University of Alberta Press and Parkland Institute. Edmonton. 2000.

[2] Canada Health Act (R.S. 1985, c. C-6). *Section 7. Program Criteria.* www.laws.justice.gc.ca/en/C-6/text.html. 2002.

[3] McBane, Mike and Wiggins, Cindy. *Vancouver and Victoria Hearings.* www.healthcoalition.ca/hearings.html. March 20, 2002.

[4] Begin, Monique. *Revisiting the Canada Health Act (1984): Impediment to Change?* p. 6. Institute for Research on Public Policy 30th Anniversary Conference. Ottawa. February 20, 2002.

[5] *ibid.*

[6] Canadian Institute for Health Information. *Health Care in Canada 2000: A First Annual Report*. www.cihi.ca/HealthReport2001/highlights/light_5.html. 2002.

[7] Ballermann, Elisabeth. *Klein Cuts amount to Forced Political Donation for HSAA Members!* HSAA Challenger 13(3). April. 2002.

[8] Alberta Liberal Caucus. *Public Health-care System Faces Acute Shortage of Diagnostic Technicians.* Alberta Liberal Caucus Communications. April 18, 2002.

[9] District 1199 Northwest Hospital and Health Care Employees Union, SEIU, AFL-CIO [Professional, Technical Skilled Maintenance and Other Employees] and Stevens Hospital. *Collective Bargaining Agreement effective March 30, 2000 through September 30, 2002.* Seattle. 2000.

[10] Health Sciences Association of Alberta (Paramedical Professional/Technical Employees) and The Provincial Health Authorities of Alberta. *Collective Agreement effective April 1, 2000 to March 31, 2002.* Edmonton. 2000.

[11] Rach, June. Registrar for Alberta Association of Registered Nurses (AARN). Personal Communication May 9, 2002.

[12] Health Sciences Association of Alberta. *Submission of the Health Sciences Association of Alberta Re: The Health of Canadians- the Federal Role to the Standing Senate Committee on Social Affairs, Science and Technology [Kirby Commission].* Edmonton. October 17, 2001.

[13] Lewis, Steven and Maxwell, Colleen. *Decoding Mazankowski: a symphony in three movements.* p. 22. HealthcarePapers on the web. 2(4) pp. 20-26. [Longwoods Publishing] www.healthcarepapers.com. 2002.

APPENDIX A

HSAA DISCIPLINES

P = professional
T = technical
S = support

Aboriginal Hospital Representative P	Case Aide P
Accounting Clerk/Typist S	Case Coordinator P
Accounting Clerk/Typist T	Child Care Counsellor P
Activities Convenor S	Child Care Worker P
Addiction Therapist P	Child Development Educator P
Admin Support S	Child Development Worker P
Administrative Assistant S	Child Life Specialist P
Advertising Rep T	Child Life Therapist P
Aide S	Child Mental Health Therapist P
Ambulance Driver T	Clerk S
Anaesthesia Technician T	Clerk Typist S
Analyst P	Clinic Assistant T
Apnea Technician T	Clinical Coordinator P
Assessment/Behavioral Technician P	Clinical Engineer P
Audiologist P	Clinical Equipment Specialist. T
Audiology Technician S	Clinical Information Specialist P
Audiology Technician T	Clinical Instructor (Technologies) T
Audiovisual Technician T	Clinical Practitioner P
Behavioural Specialist P	Combined Lab & Xray Technician T
Biomedical Technologist T	Community Health Representative S
Biomedical Equipment Technologist T	CookS
Cardiology Technologist T	Cook T
Cardiology Tech Trainee T	Coordinator S
Cardiovascular Perfusionist T	Coordinator Heriditary Services P
Carpenter S	Coordinator Volunteer Services S

Crisis Intervention Worker P	Education Consultant P
Data Analyst S	Educator P
Data Coordinator S	Electrician S
Data lnput Clerk S	Electroencephalograph Technologist T
Dental Assistant S	Electromyograph Technologist T
Dental Assistant T	Electronics Technician T
Dental Clerk S	Electronystagmograph Technician T
Dental Hygienist P	Emergency Medical Responder T
Dental Technician T	Emergency Medical Technician T
Diagnostic Sonographer T	Emergency Vehicle Operator T
Diagnostic Therapist T	EMG Assistant T
Dialysis Technician T	Environmental Health Officer P
Dietary Aide S	Environmental Services Aide S
Dietary Technologist T	EnvironmentaL Technologist T
Dietitian P	Evaluation Analyst P
Dietitian/Nutritionist P	Exercise Specialist P
Dispatcher T	Exercise Therapist P
Donor Service Representative T	Family Counsellor P
Dosimetrist T	Family Planning Facilitator P
Early Childhood Development Specialist P	Family Specialist P
Early Intervention Coordinator P	Family Support Worker P
Early Intervention Programmer P	Food and Nutrition Technologist T
Early Intervention Specialist P	Food Services Aide S
Early Intervention Worker P	Forensic Counsellor P
Editor T	Genetics Associate P

Genetic Counsellor P	House Parent S
Geriatric Rehabilitation Consultant P	House Parent Assistant S
Gerontologist P	Housekeeping Aide S
Glassware Attendant T	Imaging Services Technologist T
Health Educator P	IPG Technician T
Health Educator Genetics P	IVF Laboratory Technologist T
Health Promotion Coordinator P	Infection Control Epidemiologist P
Health Promotion Facilitator P	Infection Prevention Practitioner P
Health Promotion Facilitator/Dental Hygienist P	Information Specialist S
Health Promotion Specialist P	Injury Control Coordinator P
Health Record Administrator T	Isokinetic Analyst P
Health Record Technician T	Intake Service Coordinator P
Health Service Educator P	Janitor S
Home Care Supervisor S	Kinesiologist P
Home Economist P	Lab Assistant/Attendant/Helper T
Home Health Aide S	Lab Clerk Typist/Data Entry Clerk T
Home Maker S	Laboratory Scientist P
Home Service Therapist P	Laboratory Technologist T
Home Support Aide S	Laundry Attendant/Worker S
Home Support Supervisor S	Librarian T
Home Support Worker S	Licensed Practical Nurse S
Home Visitation Advocate S	Life Skills Coordinator P
Hope Coordinator P	Magnetic Resonance Imaging Technologist T
Hospital Illustrator T	Mail Clerk S
House Attendant T	Maintenance Worker S

Mammography Technologist T	Nurse T
Media Producer T	Nurse Practitioner P
Medical Illustrator T	Nutritionist P
Medical Library Technician T	Occupational Therapist P
Medical Ophth Retinal Photographer T	Office Assistant S
Medical Radiation Technologist T	Operating Room Aide S
Medical Typist S	Ophthalmic Assistant T
Mental Health Clinician P	Ophthalmic Technician T
Mental Health Consultant P	Orthopaedic Footwear Technician T
Mental Health Outreach Worker P	Orthoptist P
Mental Health Rehabilitation Counsellor P	Orthotic Technician T
Mental Health Therapist P	Orthotist P
Messenger S	Outreach Coordinator P
Methodologist P	Outreach/Leisure Coordinator P
Methods Analyst P	Outreach Worker P
Molecular Associate P	Parent Services P
Molecular Genetics Assistant P	Pathology Technician T
Mould Room Technologist T	Patient Employment Officer P
MRI Technologist T	Payroll Clerk S
Music Therapist P	Payroll Officer S
Neonatal Practitioner P	Perfusionist T
Neuro Muscular Clinic Coordinator P	Perinatal Practitioner P
Neuropsychologist P	Personal Care Attendant S
Neuropsychology Technician T	Pharmacist P
Nuclear Medicine Technologist T	Pharmacy Assistant S

Pharmacy Technician T	Receptionist S
Pharmacy Technician Coordinator T	Recreation Therapy Aide S
Physical Therapist P	Recreational Therapist P
Physio/Occupational Therapy Aide S	Regional Dietitian P
Physiological Laboratory Technologist T	Registered Emergency Paramedic T
Physiotherapy Aide S	Registered Nursing Attendant S
Play Therapist P	Registered Orthopaedic Technologist T
Polysomnographic Technologist T	Rehabilitation Assistant S
Porter T	Rehabilitation Consultant P
Printshop Operator S	Rehabilitation Coordinator P
Procurement Clerk S	Rehabilitation Engineer P
Program Facilitator P	Rehabilitation Engineering Technician T
Prosthetic Technician T	Rehabilitation Practitioner P
Prosthetist P	Rehabilitation Therapy Assistant S
Psychogeriatric Consultant P	Research Assistant P
Psychologist P	Research Project Coordinator P
Psychology Assistant P	Research Technologist T
Psychology Technician T	Research and Planning Officer P
Psychometrist P	Residence Counsellor P
Psychometrician P	Residential Counsellor P
Psychotherapist P	Resource Liaison P
Public Health Inspector P	Respiratory Therapist T
Pulmonary Diagnostic Technologist T	Screening Coordinator P
Purchasing Assistant S	Seating Coordinator P
Radiation Therapist T	Seating Technician T

Secretary S	Typist S
Service Aide S	Unit Clerk S
Sexual Health Consultant P	Unit Secretary S
Sleep Disorder Specialist P	Utility Worker S
Sleep Technologist T	Work Evaluator P
Social Worker P	Working Leader S
Speech Lang Pathologist/Therapist P	Working Supervisor Admitting S
Speech/Hearing Coordinator P	
Steno S	
Stores Accountant S	
Stores Attendant S	
Support Services Worker S	
Support Services Manager S	
Surgical Processor S	
Switchboard Operator S	
Systems Analyst P	
Systems Support Analyst P	
Teacher of Hearing Impaired P	
Technical Instructor T	
Telerecruiter T	
Testing Assistant T	
Therapist P	
Therapy Assistant/Aide S	
Tobacco Coordinator P	
Transport Driver T	

APPENDIX B

HEALTH SCIENCES ASSOCIATION OF ALBERTA

SUBMISSION

to

THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

re:

THE HEALTH OF CANADIANS - THE FEDERAL ROLE
VOLUME FOUR: ISSUES AND OPTIONS

Edmonton, October 17, 2001

HEALTH HUMAN RESOURCES

INTRODUCTION

As stated at the outset of Chapter 11 in the report of the committee, there is great plausibility in the assertion that there is a crisis in relation to health care human resources.

Unfortunately, much of the emphasis in recent years regarding this crisis has been on physicians and nurses - with allied health workers (paramedical professional and technical) often being seen as an afterthought.

As a result of a multitude of factors - which are discussed in this submission - there is a general labour shortage in many of the allied health disciplines. All indications are that this is not a short-term problem, but one that will persist for years to come. Following is a list (not exclusive) of some of the allied health disciplines that are currently facing labour shortages:

Professional	Technical
Physical Therapist	Cardiology Technologist
Occupational Therapist	Pharmacy Technician
Speech Language Pathologist	Radiography Technologist
Orthotist	- general duty
Audiologist	- special procedures (i.e. CT)
Pharmacist	Magnetic Resonance Technologist
	Diagnostic Sonographer
	Nuclear Medicine Technologist
	Medical Laboratory Technologists
	Respiratory Therapists
	Physiological Laboratory Technologists
	Clinical Perfusionists
	Registered Emergency Paramedics
	Cytogenetics Technologists
	Radiation Therapists
	Electroneurodiagnostic Technologists
	Public Health Inspectors

If the issues relating to the shortage of allied health workers are not addressed, the implications for diagnostic and therapeutic services will intensify, exaggerating the problems currently faced in our health-care system.

In this submission, HSAA will highlight those factors which it believes influence the health human resources issues which are present today; and provides recommendations for the federal government to undertake in its role of guardian of the Canadian health-care system.

ISSUES

1) *Invisibility of Allied Health Workers*

The invisibility of allied health workers, in the context of the broader health human resources issues, is a perpetual problem, and one that has a distinct impact on the quality of our health system.

While volume four of the committee report gives credence to the fact that allied health workers “receive less attention but are no less important to the smooth running of the system”, there is little discussion about the causes of the human resources problems of health professionals.

For instance, we have seen several human resources strategy initiatives in the health-care sector in the past few years. One example is *A Nursing Strategy for Canada*, written by a subcommittee of the Advisory Committee on Health Human Resources. The report is a comprehensive analysis of nursing human resources issues, and recommends 11 key strategies in dealing with human resources issues for nursing. To date, there has been no such equivalent analysis of issues and strategies for allied health workers, despite the fact that the issues for allied health workers are as serious as they are for nursing, and, in some cases, far more serious.

It is imperative that the federal government, in its role of planning and financing the national health-care system, recognize the role that these employees play in the system; and simply do not restrict itself primarily to nursing and physician issues.

2) *Working Conditions of Health Professionals*

The committee's report recognizes the stress on the current health-care system, and the resulting impact on the working conditions of allied health professionals. The problem can accurately be characterized as "working more with less", which is a source of stress and uncertainty for most allied health workers.

One good example of this is Nuclear Medicine Technologists, who in Alberta routinely run diagnostic scanning procedures in two or three rooms at a time, when the preferred level of care is one room/patient at a time. Not only are there the obvious patient care implications of this, but it is also causing burnout. There may be a few adrenaline junkies who thrive on this level of work, but this level of work is not sustainable in the long run.

The result is that allied health workers are working longer hours, including an ever present requirement to work extensive overtime and callback, which has led to many employees leaving the public system; either moving to the private sector because hours of work are more desirable, leaving the country, or simply leaving their profession.

For those left behind, the overload of work creates an even greater stress, and perpetuates the retention issues that hospitals are now facing.

Another issue is the "casualization" of the workforce. Despite the fact that permanent full-time and permanent part-time jobs are the best means of recruiting and retaining employees, there is an ever present increase in the utilization of casual employees.

General quality of work life issues also have an impact on the current labour shortage. Problems such as decreased career advancement opportunities, lack of support for continuing education, and inflexible work schedules also play a part in the labour shortages.

Because of the invisibility of allied health workers, there must be a concerted effort to convince the youth of today and tomorrow that these are attractive careers options. But just as important as recruitment to these professions, is placing an emphasis on resolving workplace conditions so that once employed in the profession, the employees will stay and provide a full and productive career.

3) *Government Budgeting Practices*

Over the past two decades, we have seen both provincial and federal governments conducting short-term budget planning - which can, and does, cause havoc with long-term human resources planning in health care.

There has been too much unpredictable funding, short-term planning windows, and "one-time" funding for health projects. This is not only in health care, but also in the advanced education sector which trains health professionals of the future. All of this results in cycles of hiring shortages and layoffs. Also contributing to this problem is inter-provincial competition for scarce resources - "robbing Peter to pay Paul" when employers in one province pay incentives to promote professionals to migrate.

The current crisis is indicative of these practices. The reduction in federal health transfers and the budget cuts of the provinces during the 1990s resulted in a large number of allied health workers leaving the province, country and profession. It is clear now that the effects of three or four years of budget cuts may take a decade or more to stabilize the system and get staffing back to appropriate levels.

Adding to the problem of the loss of professionals in the public health system, was the cut in advanced education. Enrollment in many programs were cut back through a combination of cuts to health care and advanced education. An example is Medical Laboratory Technology in Alberta, where training schools cut enrollment from 40 students to 20 students.

Therefore, when budgetary constraints improved a couple of years later, not only was there not a group of laid off employees waiting to get their jobs back, but there were also not nearly as many new graduates coming from the technical colleges and universities to fill vacancies.

To take an even longer-term perspective, enrollment in colleges and universities has not only not kept up with the expanding demands of health care, but many of them have actually decreased. Human Resources Development Canada (in its Job Futures 2000 Program) indicates that many allied health worker disciplines have seen a decrease in the number of graduating students. For example, HRDC indicates that in 1997, there were 530 graduates from medical laboratory technology programs across the country - a 42% decrease from 1987. Diagnostic Imaging had a 15% decrease in graduation

over the same period. This is an astounding figure, considering the ever increasing demand for technical and professional employees due to both the new technologies and a growing population.

A stable funding formula for health and health education is essential for any strategic human resources strategy to succeed. As long as short-term financial planning prevails over long-term human resource planning, Canadians will continue to experience the problems we face today.

4) *The Expansion of Private Health Care*

The impact of the expansion of the private health-care sector on human resource planning in the publicly funded system is staggering. In short, the private system is bleeding the public system of talented and desperately required professional employees.

There is an overlap between the private and public sectors for most allied health professions. Unlike the nursing profession, the private sector is permeated with allied health workers. Take for example, diagnostic imaging. Private radiology groups are gradually taking over a significant component of radiology work. The private sector in radiology in Alberta offers comparable wages, but usually better working hours and conditions (i.e. less shift work, weekends and call-backs). As a result, we have seen an exodus of diagnostic imaging technologists to the private sector. However, the expectation for services in the public sector has not diminished, which in turn creates an overburdened workforce of employees who remain in the public sector. The sometimes intolerable working conditions create a vicious circle, where recruiting and retaining employees in hospitals become even more difficult because of the demands of the job. Given the current situation, it is unlikely that the “brain drain” from public health care to private clinics will abate any time in the near future.

Another example of private sector competition affecting the public sector is in pharmacy services. Because of the international shortage in Pharmacists, the private sector has been paying much higher wages than the public sector. Beyond wages, the profit sharing and other compensation schemes can result in many Pharmacists earning $20,000-$30,000 a year more in the private sector.

It is unrealistic to expect health-care workers not to respond to salary offers that are significantly higher. Therefore, public sector pay and benefit levels must be sufficient to attract and retain allied health workers.

In summary a failure to address the creeping privatization of health care will, without question, escalate the shortage of qualified health professionals in the public system.

5) *Educational Requirements and Pay Implications*

Allied health workers have seen an explosion in the knowledge and technology they are required to master in the past decade. The knowledge required has become so extensive that many educational programs have, or are considering, increasing the length of their programs.

One such area is the diagnostic imaging group of occupations. The complexity of radiography and nuclear medicine has evolved so dramatically that the Michener Institute in Ontario has recently moved from a two-year program in medical radiation technology and nuclear medicine, to a five-year program. Other modalities such as Magnetic Resonance Imaging have become a "second discipline", requiring further post-secondary education.

In Alberta, there is a proposal to change Physical Therapy to a masters level program for entry to clinical practice.

These are all examples of "credential creep", which we are seeing on an ever increasing basis in the allied health professions.

The extended training requirements for these programs may mean that there will be fewer qualified applicants due to the time considerations; for some disciplines it clearly will result in a lag of graduates during the transition years, and may lead to more attrition in the number of graduates. All of these factors will have an implication in the ability of the health care system to attract and retain employees for the foreseeable future.

An added impact of credentials creep is the fact that there will be an expectation of graduates to be remunerated to reflect the additional education. In making career choices, young people eventually look to remuneration, as well as job opportunities and security. The brightest and the best have the greatest amount of choice - and therefore in order to attract the people required for this area of work, there must be a relationship between the level of education and pay.

This is where the invisibility of allied health workers also becomes a significant problem. The emphasis by all levels of government over the past few years on the nursing shortage has led to wage settlements for nurses being much higher than for allied health workers - to the point that relative wage levels for nurses with two years of education are equal to, or higher than, many allied health professionals with four or more years of advanced education. If bright, talented students who want to work in a health profession have a choice of taking a two-year nursing program or an allied health professional program - with the former having a substantially higher pay upon graduation - it is likely that enrollment in these programs will not increase as required.

The impact of this has not yet been seen as this is a relatively recent phenomenon, but unless equity is restored in terms of pay, the shortage will only be exacerbated. The "nursing problem" might be alleviated, but another equally difficult problem is being created.

OPTIONS

The committee asks the questions in its summary of human resource planning problems: "what role should the federal government pay in the development of a national human resources plan for all health services sector personnel?"

HSAA provides the following recommendations:

1. *Federal Role in Human Resource Planning*

   HSAA concurs with the committee that a national long-term health human resources strategy is required. This would include research and data collection of the current workforce. It would also include a comprehensive and ongoing analysis of forecasted labour market needs.

   It is imperative that any such national strategy not give in to historical patterns of focusing on nursing and physicians; instead, it must effectively plan for the Human Resources issues for all health professionals.

   Due to inter-provincial mobility, we have in fact a national labour market for most health professions, which is why the federal government must take a leadership role in the strategy. Provincial governments working in isolation will not meet national objectives in this regard.

2. *Stable Funding Resources*

   Even if a comprehensive national human resources strategy is conducted, if short-term budgetary planning persists for both health and advanced education for health professions, we will continue to experience labour market crises that we have seen in the past and present.

   Therefore, the HSAA recommends that the federal government work with the provincial governments to ensure that - based on the outcomes of a national human resources strategy - a system of stable health-care funding be implemented.

3. *Profile of Allied Health Workers*

HSAA recommends that a communication strategy be developed for the purpose of increasing the public profile of the allied health professions as a career of choice - with the goal of increasing the number of qualified applicants to the various programs across the country.

4. *Limits on Creeping Privatization*

As stated earlier in this submission, the fact that there is an alarming increase in the private health-care sector coupled with the fact that the number of allied health professionals graduating is relatively stagnant, results in the bleeding of qualified professionals from the public sector to the private sector. As a result, hospitals across the country are starving for health professionals and will continue to do so as long as the private sector is competing for the same labour resources.

Therefore, HSAA recommends that the federal government fulfill its role as guardian of health care, by supporting the *Canada Health Act* and slowing the insidious creep of the private health sector.

CONCLUSION

The future of health care in Canada is the most important issue facing Canadians today. The work of this committee and other commissions on health care is essential for both the preservation of the health-care system, and creating solutions to some of the vexing problems facing us. The scope of this project is vast: funding and financing, preservation of *The Canada Health Act,* pharmacare and home care initiatives, and many other important issues. Recognizing that while human resources planning is only one component of the larger picture, it is an essential facet for an effective and efficient health-care system; and human resources planning must be more effectively managed for all health-care professionals, for the benefit of the system as a whole and for all Canadians.