Health Human Resources

British Columbia’s health care workforce was a common discussion topic among participants in the Conversation on Health. Demands on health human resources included comments on scopes of practice, rural demands, the demands between the private and public sectors, remuneration of professionals, and the management and leadership structure of health care. Labour relation discussions centered on essential services, collective bargaining, and the roles of unions and professional associations in the bargaining process. Here is a sampling of what British Columbians had to say about health human resources.

Health Human Resource Demands

British Columbia’s baby-boomers are retiring in large numbers and subsequently, the health care sector is set to lose many knowledgeable and skilled health professionals. Participants are concerned that the number of new medical professionals entering the system will be insufficient to meet current or projected demands for health human resources. Participants also express concern about the accessibility of general practitioners, citing difficulty in finding a family doctor who is accepting new patients. Many agree that filling more full-time positions with practitioners from on-call and part-time pools may alleviate some demands and workloads. Further, some suggest employing health professionals past retirement age to mentor and train new staff.

In an effort to recruit more people into a career in health care, participants suggest hosting job fairs and offering aptitude testing to encourage those best suited to the health profession. Volunteer services such as candy stripers, they argue, should also be utilized and the program expanded to offer more exposure to careers within the health sector for youth. Some participants argue that the staffing shortage could be resolved by subsidizing student’s tuition and increasing available training spaces at colleges and universities. Additional recommendations include ideas around catering to the values of younger generations, by offering a more flexible working environment and schedule, and creating a healthier workplace with gym facilities, and more child care options.
Some participants also suggest that increasing the number of Aboriginal practitioners on all levels would aid in the delivery of culturally appropriate care to those who need it, while increasing awareness of these cultural sensitivities to the rest of the practicing field.

*We need to anticipate and recognize the current and future shortage of health care professionals by investing in training, retention, recruitment, and support strategies… [and] maximizing the scope of practice of clinical and support personnel.*

-Health Professionals meeting, Burnaby

**Scope of Practice**

Participants view changing scope of practice as a tool to fill service gaps and to allocate health human resources more effectively. Some strongly believe that British Columbia’s nurses are capable of assuming a greater role within the health care system. They also think that nurse practitioners could both take on a greater, possibly managerial responsibility within clinics, and triage patients as they enter emergency departments. Participants also suggest increasing the role and availability of community health nurses to enhance rural accessibility to health services.

Many participants want access to new and under-utilized services in order to improve the health human resources picture in British Columbia. They believe that general practitioners should not be the sole gate-keepers to health care and pointed to complementary therapies as alternate points of treatment. Others regard midwifery as another beneficial service, which should have expanded duties and hospital privileges. Participants also discussed creating a patient ombudsman or patient case manager, who would direct patient care in a more organized manner. This, they argue, would reduce duplicate and unnecessary testing or treatment. Other participants think volunteer services should be relied upon to provide basic services and free up medical professionals who are currently responsible for these duties.

**Rural and Remote demands on Health Human Resources**

Many participants voice concerns around the current process for the recruitment and retention of health professionals in rural and remote areas of British Columbia. Offering incentives such as subsidizing housing for practitioners and their families, and financial incentives to practice in rural areas would bolster human resources to satisfactory levels. Newly-graduated and foreign trained professionals could be required to practice in northern and rural British Columbia for a number of years to
help alleviate the chronic staff shortages these areas experience. Some think that ambulance services in rural and remote areas need to be upgraded by increased funding and staffing, as many participants raised concern over the extremely long waits for ambulance services.

Public versus Private Demands on Health Human Resources

The issue of public versus private practice created significant debate around health human resources. A number of participants believe that a private system would drain the public stream of its practitioners by offering higher rates of pay and more flexible working conditions. Others believe that a private health care system would be a relief to the overcrowded public system, while some were proponents of a dual delivery system that regulated the amount of time a practitioner spent in each area. Some participants raise concerns about the efficacy of privatized cleaning, food, and laundry services. There is a perception that hospital cleanliness and patient safety have been compromised as a result of privatization and that, due to a low number of sanitation staff, nurses must take on cleaning duties that only compound their workloads.

There is the difficulty [in] trying to keep physicians working in the public system if they can make more money in the private system.
- Web dialogue, Kamloops

Remuneration of Health Professionals

Participants voice concerns that the current fee-for-service remuneration model for physicians is not conducive to the provision of quality health care. They feel that the limit in the range of the Medical Services Plan (MSP) insured services make some treatments unavailable. Many participants also express concern that the 10-minute visit fee is inadequate or insufficient to fully diagnosis a medical problem. Some suggest offering a salary to practitioners as a way to address the issue of appointment times. Participants also suggest upgrading the salary models of ambulance crews to create more full-time positions in rural and remote areas of British Columbia.

Administration, Management and Leadership

The Conversation on Health touched on the professional management and leadership structures within the health care system. Participants view good leadership as critical to the efficient operation of the health system and to maintaining the morale of front-line workers. Some participants expressed concerns over what they believe are
unnecessary and expensive executive contracts and large severance payouts. Many participants would like to see a reduction in the level of bureaucratic and administrative staff and the devolution of responsibility to those working on or nearer the front-lines of care. Such a move, they believe, would require leadership and management training for primary care practitioners willing to take on such a role. Establishing head nurse and team leader positions would provide a good foundation for promoting discipline and efficiency in the various departments.

*There seems to have been a rapid increase in the number of middle management positions in the health care system that often overlap and have no tangible or measurable impact on the way health care is delivered.*

-Dialogue, Langley

**Collective Bargaining**

There is some concern that long-term contracts only last one year with insufficient time for re-negotiation. Participants believe that all the medical professions should be brought to one table at once to facilitate coordinated bargaining. Many believe that this single representation would result in a more focused approach and result in a more cohesive health care system.

Some participants suggest that contracts should be performance-based, with a process implemented for requesting a review when something fundamental has changed. Others argue that too much health policy is negotiated in the context of a collective agreement.

Many participants suggest that collective agreements be revamped to offer more flexibility to health professionals. Collective agreements may have placed too many restrictions on employees resulting in some jobs being done incorrectly or not at all. Participants cite the cleaning of hospitals as a common example.

*If we’re going to a change management process effectively, then we’re probably going to have to have some short-term expert to help deal with some of the labour relationships issues that are going to emerge from this, and that’s where some of the… extra money would need to be invested.*

-Primary Health Care Focussed Workshop, Vancouver
Unions and Professional Associations

Many participants state that there should be a mutual understanding between management and unions that client services remain the most important issue. Currently, they believe, there is an environment of conflict between governments, employers and unions. Some argue for more collaboration among all unions and the government on necessary health care changes. For some participants, this means strengthening the Government’s role in dealing with health professionals and ensuring interest groups are not responsible for making decisions.

Essential Services

Many participants consider health care an essential service. Mediation and meaningful negotiation is considered important, but many participants believe that labour strikes should not be allowed: the focus should be on delivering satisfactory health care to patients. Some participants state that, if a strike lasts longer than a week, those workers be replaced. Others express concern about the importance of providing health services around the clock and the practicality of health professionals taking extended vacation.

Conclusion

British Columbia’s health care professionals are retiring in record numbers. A province-wide effort to increase recruitment and retain professionals is necessary. Options such as expanding practitioners’ scopes of practice and creating new types of practitioners could address shortages more quickly. Participants suggest the province take affirmative steps to increase the number of health care providers in northern and rural communities, guaranteeing all British Columbians timely access to care. Health services could be delivered by a professional in either the public or the private system, or from both systems. A number of people would like to see more discussion and collaboration among unions and government to ensure needed changes in the health care system will be implemented and supported. Having more time to discuss issues with one’s general practitioner may require a reform in the way health professionals are paid, such as moving away from a fee-for-service model to a salary model. Finally, many participants call for a sizeable reduction of administrative and executive staff, and a shift towards granting more authority to the front-lines of health care.
Health Human Resources

This chapter contains the following topics:

Health Human Resource Planning
Recruitment and Retention
Leadership, Administration and Management
Labour Relations

Related Electronic Written Submissions

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Related Chapters
Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Training, Morale, Access and Public Private Debate.

Health Human Resource Planning

Comments and Concerns

Health Human Resource Planning
Public versus Private Demand

• Comments on health human resource planning:
  • Funding is available for new and innovative health initiatives; however these initiatives require human resources that are simply not available.
  • British Columbia’s health care system seems to be operating at 130 percent of its capacity without additional staff.
  • There has been very little effort to increase the utilization of allied health professionals to try and address human resource shortages.
  • The majority of health human resource planning has been provider-based analysis as opposed to a needs-based analysis.
  • There has been a shortage of nurses and doctors ever since adoption of the recommendations contained in the Baring report fifteen years ago; suggesting limitations in the number of entrants to medical and nursing schools.
  • Doctors dictate their locations of practice and their billing system, effectively ignoring Provincial and public requests for practice in under-served areas.
  • The Canadian Medical Association is lobbying against generalists and not allowing their full integration into the system.
  • There are physical limits as to how much volunteers really can do to help.
  • A greater use of volunteer services will result in a net loss in health care positions.
  • There is a general lack of respect for volunteers and their services.
  • There are physical limits as to how much volunteers really can do to help.
  • A greater use of volunteer services will result in a net loss in health care positions.
  • There is a general lack of respect for volunteers and their services.
• When a phase-one clinical trial volunteer re-locates to Vancouver, the only medical resources available to them are the phase-one clinical trial team, whose interests are contrary to those of the patient. The government pays nothing towards the care of these terminally-ill patients.

• There are many professionals available but no full time permanent jobs.

• New medical graduates have a lot expected of them. They will be expected to do far more, or be criticized that they are not as good or efficient as those who are retiring. A person with 30 years experience can multi-task, even though the young person is trained in multi-tasking, they just do not have the work experience. In addition to a loss in numbers, the province is also looking at a loss of experience which cannot be replaced one-for-one. This will have a large impact on how productive the health care system is going to be.

• Despite the present and projected nursing shortages in British Columbia, many nurses seeking work in communities that actually need nurses cannot get full-time jobs. Instead, they must suffer the inconvenience and insecurity of the casual list system. This often persists for two or three years until a nurse achieves enough seniority to win one of the scarce and coveted full-time positions.

• The Provincial Government has yet to roll out a long term strategy for recruiting and retaining health professionals specializing in care for seniors.

• Midwifery is not attracting new practitioners due to low pay and little in the way of incentive.

• The Trade Labour and Investment Mobility Act (TILMA) is aiding in the destruction of communities.

• Human resource hiring systems do not always support the hiring of Aboriginal practitioners.

• Simply increasing class sizes may not be a viable option as doing so will significantly increases costs to universities.

• Universities are not providing enough training seats to address the health human resource crisis.

• Health professionals are retiring at a much faster rate than they are being replaced.

• The health human resource system creates a division between physical and mental health; the mental health side is marginalized not only in training but also in practice.

• British Columbia does not suffer from a shortage of available labour, there is simply a lack of willingness to utilize many practitioners to their full potential.
• Hospital capacity issues are not the result of a lack of doctors but often result from a lack of post-operative care and a lack of basic cleaning staff to cycle facilities for the next patient.

• The human resource issue is viewed almost entirely a numerical problem, but there is also enormous and persistent evidence that it is a distribution problem. There are not enough physicians and specialists working in rural areas when there is a virtual saturation of urban areas with all types of personnel, and yet people still report that they are unable to receive care from a family physician. The ratio of family physicians to citizens seems to have no effect on this phenomenon.

• The Health Human Resources Advisory Committee was not solution driven.

• There is little evidence-based planning when allocating health human resources.

• Many participants viewed staff sitting idle within hospitals.

• There is a lack of residency positions for International Medical Graduates (IMG)s.

• The current health human resource scenario represents a seller’s market for labour. Management has to implement a cost-benefit analysis every time new labour is needed therefore a simple mathematical tool to assist in hiring is would speed up the process.

• Too many locums prevent a continuity of service to patients.

• Human resource figures and statistics are irrelevant. The ratios reveal almost nothing because health human resources comprise a mix of professions. It is the entire package of personnel and what they do that matters.

• There is a need to recognize that health care workers cannot do at 60 what they once could at the age of 30. Asking them to extend their working terms past retirement may be impossible.

• British Columbia must rely on recruiting International Medical Graduates (IMGs). International Medical Graduates make significant contributions in medical services, however to make our health system sustainable, British Columbia should work towards self-sufficiency in producing its own medical workforce. The alternative is to tolerate a reduction in the availability of medical services at the very time that an aging population will require more services. Compounding this problem is the fact that British Columbia’s physicians are aging.

• Although there is talk about a shortage of workers, nothing constructive is being carried out to address the issue.

• Provincial re-certification is limiting the movement of professionals to higher demand areas in other provinces.
• Students are still waiting many years to enter into medical school or nursing programs; this shows extremely poor human resource planning when taking into account British Columbia’s critical human resource shortages.

• Multiple unions, multiple employers, and multiple professional bodies increase the vastness and the complexity of the health care system.

• The health care system has been characterized from its inception by an absence of anybody responsible for long-term human resource planning.

• There is a need to ensure that any mathematically based health human resource planning models are realistic. Currently, while implementing a health professional, one assumes that that professional will be operating at 100 percent of their capabilities, however this 100 percent efficiency is not always the case as some professionals will work harder than others.

• Local businesses suffer when health sector positions are eliminated within their regions.

• Comments on public and private demand for resources:

  • The Province must stop health professionals from double dipping, or working in both the public and private sector.

  • The use of doctors in walk-in clinics is a waste of the taxpayer’s money as these physicians may not be working full time. In the face of such a labour crisis, they should be required to do so.

  • Doctors are working in the private sector simply because they will earn more.

  • Health care services in Provincial prisons have been privatized. Registered Nurses were provided with the option of severance package or being hired on with the new owners and consequently, nursing services have been reduced. A Vancouver jail has had two Registered Nurses per shift 24 hours a day since the 1960s. Now the jail has had its health care centre closed several nights in a row, including some weekends. Licensed Practical Nurses have been introduced to the Vancouver jail but cannot work without the presence of a Registered Nurse. Prison nursing is a specialty that rarely incurred vacancies yet many nurses now refuse to work for an inferior collective agreement, leaving the jail without service. This is a great cost to lower mainland resources as inmates are transferred to our emergency rooms for care that a Registered Nurse could have provided. Two police officers must escort inmates with emergency health services staff, allowing profit to flood out of the of prison health services budget.
• A private clinic siphoning talent from the public system should be accepted as a non-issue; British Columbia is already losing talent to private systems around the world.

• I think that in a mixed delivery system, we will see a real problem with attracting and maintaining critical services in the public hospitals. Nurses and doctors will be siphoned from the public system into the private where there is more money.

• British Columbia’s health human resource pool will not sustain two separate systems.

• Why is it that in the time of so called budget restraints we are continuing to contract out so many of the services that could be done in-house at far less cost.

• The brain drain or loss of trained professionals is working against the Canadian public services and into the hands of private American organizations.

• In a healthcare system offering both public and private care options, higher quality doctors would leave to find employment in the private sector. Private sector care would be out of reach of the poor, and the public sector would continue into their human resource crisis.

• Private sector care has their own recruitment and retention problems because working conditions in private settings are so poor that nurses will not stay within them.

• No contractors of any kind should be allowed in hospitals.

• The privatization of house keeping and food services has compromised two of the most important patient services within the hospital.

• The retention of quality workers is becoming harder for the privatized companies and it is the public that suffers.

**Ideas and Suggestions**

**Health Human Resource Planning**

**Public versus Private Practice Demands**

**Education and Training**

• **Ideas about health human resource planning:**

The made-in-British Columbia solution to addressing health human resources must be part of a more integrated made-in-Canada solution and the two must go hand-in-hand. It is wrong to think that British Columbia can single handedly solve its
health human resource problem; all we are doing is merely export that problem to other parts of the country.

- British Columbia requires only a temporary infrastructure of doctors and health workers to care for the oncoming baby boomers. If the province commits to permanent infrastructure and labour, there will be a resounding surplus once this crisis has passed.

- Encourage greater mobility for doctors within Canada. Break down any barrier that would stop professionals from crossing provincial borders. Create a national professional jurisdiction to facilitate movement of professionals from one province to another.

- Administrators should be able to foresee shortfalls in staffing and plan to avoid these problems.

- The current global population is not able to provide for the upcoming demand for labour. Encourage people to have more children.

- Public input must be incorporated into deciding appropriate staffing levels for acute and chronic care. This would include not just nurses, but also Physiotherapists, Occupational Therapists, dietary, laboratory, and all other support services.

- All British Columbian medical school graduates should be required to work within the province for a span of five years. They would be repaying the taxpayers for their subsidized educations.

- Eliminate the Trade, Investment, and Labour Mobility Act (TILMA) or at least modify it to exclude health care.

- Open up and address the human resource issues brought on by the North American Free Trade Agreement (NAFTA).

- Creation and sharing of casual job pools between facilities.

- Triple the amount of community support workers being trained and employed.

- It is about time we got rid of some of the non-productive employees, not hire more. It is no wonder that Canada's productivity is at an all time low.

- Invest in workforce planning and require individual units or departments to conduct annual performance evaluations for all staff.

- British Columbia must confront the issue of inter-provincial competition for health human resources in a serious manner.

- Health human resource planning must be backed by the Premier's Office.
• Implement mathematically-based health human resource planning models that reflect today’s reality.

• Amend legislation to make regulatory bodies accountable for supporting government health human resource planning.

• Create a pathway to keep health professionals engaged in health care in some way; for example, emergency medical personnel or ambulance attendants could be exposed to modularized training allowing them to branch into hospital operations.

• Leading edge health care research also helps British Columbia to attract and retain leading clinicians in our province.

• Focus on delivering a more integrated approach to health human resource planning; currently it is delivered in individual, professional silos.

• Create a set of indicators to mark successes in human resource planning.

• Evaluation should be integrated into policy decisions surrounding the vast complexity that is health human resources.

• Smaller, rural communities should have some level of authority when hiring health professionals.

• A prerequisite to any sort of human resource planning would be comprehensive method information gathering. Setting up stakeholder participation should include those who would be implementing the plan, having the research around the punitive need assessed and coming up with a legitimate needs assessment.

• Widen healthcare practitioner’s scopes of practice to better disperse their workloads.

• Health human resource planning should be performed in the context of operating teams and their individual roles within those teams.

• There is a need for a needs-based mechanism of distribution of healthcare personnel, which applies codes to regions in demand. Stop allowing practitioners to set up practice anywhere they see fit.

• Health human resource planning must take into account training, training spaces, promotion, and career laddering. There must be less focus on poaching from other jurisdictions, and more on the retention of the diagnostic, the clinical, and the rehabilitation personnel who already deliver services in the health care system. Laboratory technologists, x-ray technologists, dieticians, pharmacists, social workers, physiotherapists, occupational therapists, and speech therapists have not been excluded from the planning.
• The shortage of health care professionals provides an opportunity to change the approach to care. The current model consists of one-on-one treatment, a doctor and a patient. However the current crisis should be used to usher in a team-based approach, with several different types of specialist attending to a patient’s needs.

• Utilize a health liaison as the initial point of entry into the healthcare system.

• If demographics prove that a large amount of patients are going to end up in institutional care, than a re-assessment of professional requirements should be in order. Highly trained professionals are not needed in these environments.

• The physician to patient ratio in mental health services should be no more than one to every thirteen patients. It may be expensive, but in the long run less expensive than repeated inpatient care. It would also reduce crowding in emergency rooms and free up specialists to see other patients.

• New graduates who are completing their required time in the public system should be required to staff twenty-four hour clinics.

• Registered massage therapists are a fairly young workforce, with an average age of around 30. Registered massage therapists can provide a long term commitment to the public health care system.

• When one talks of health human resources, one is talking about to some degree of expanding the labour pool and making it more flexible. The response to labour shortages in the private sector is to use less labour. We may be seeing self-serve coffee houses in the future if they cannot hire staff. A self-service oriented health care system may be the answer to the looming staff shortages.

• It is vital that the Provincial Government commit to a comprehensive health human resource strategy in cooperation with the health profession. Short and long-term strategies will be required to address the existing deficiencies in health human resource numbers and assure an adequate supply in the future.

• Allow those at the front-line of the health care system to organize and implement health human resource planning. Those in managerial roles simply cannot get the right picture of what is needed.

• Directional planning and vision is needed when developing a health human resource plan. This structure would include:
  o Outcome assessments;
  o Information gathering;
  o Patient and population needs assessments;
  o A representatives forum;
  o Implementation by stakeholders;
• Rollout; and,
• An Arms-length health research evaluation panel with a flexible timeline.

- Create a federal agency to investigate long-term demographic trends in health care.
- Develop a labour plan for British Columbia focusing on the continuum of labour potential from volunteers though various part-time work, to full time. This plan might include:
  - Incentives to volunteer, particularly covering costs of volunteering;
  - Lump-sum stipends for showing up to meetings or work;
  - Increase accessibility of training for the general public in medical matters, perhaps offering courses on things like first aid free of charge;
  - Offer free public seminars or workshops on health care aimed at increasing public knowledge of care and prevention of various conditions. Topics such as osteoporosis, cardiovascular care, asthma, and diabetes could be discussed;
  - Once a person is diagnosed with a problem, ensure health system has support groups to which doctors can refer patients for further information; and,
  - Train retired professionals to build supporting networks that provide information on where to get help, assist with follow-up to treatment programs to increase compliance.

- Align the Ministries of Advanced Education and Health on goals to address the human resource issues in British Columbia.
- Canada seems uniquely fixated on trying to produce just the right number of everything. Producing just the right number of health professionals is impossible, and any planning effort is therefore doomed to failure because circumstances change. The best strategy on the numbers side is to produce a modest surplus and see how that works out.
- There is a need for data at the unit level that could be used to dictate better allocation of health human resources.
- Follow the United Kingdom and Western Europe’s models on staffing ratios.
- Matching supply with demand of health professionals requires a greater collaboration between Treasury Board officials and the Health and Education Ministries. Funding, education, and health systems need to be collaborative as well as the professions
- Send more general practitioners to work in Northern British Columbia.
• Monies saved from streamlining hospital processes should be spent on hiring more trained staff.

• Reward those practitioners who do choose to work in rural and remote settings.

• Request high School students with musical talents to come in to long-term facilities once a week to play for residents.

• British Columbia should open its doors to newly immigrated and trained health professionals.

• Financial support should be made readily available to prospective and current midwives.

• Decrease segregation of students into trades streams early in high school and create awareness around their academic options in elementary school.

• Affirmative action is necessary to address the current staff demographics. The system is imperfect and favours certain people.

• Accommodate workers with a more flexible and manageable schedule.

• Aggressively expand recruitment and retention strategies to bridge the gap between training programs and service vacancies.

• Offer incentives for existing health care professionals to stay in their field, especially to those professionals approaching retirement age.

• The Provincial Government must offer child care and housing assistance for health professionals working in the north.

• Create an expanded role for the patient advocate.

• Maintain a positive image of the health professions through the airing of televised commercials.

• Create safer workplaces that are free from harassment and violence.

• Implement a reasonable graduated retirement plan that includes provisions for mentoring, part time work, community primary care, role changes, and locums.

• Offer signing bonuses to new professionals.

• Consult with the information technology industry for ideas on how to accommodate and motivate younger workers.

• The younger generation is looking more at sustaining their lifestyles outside of the work environment.

• Create an inter-provincial, multi-disciplinary group to tackle barriers to foreign/inter provincial recruitment.
• More focus on the recruitment of community health workers.
• Employ a better proportion of nurses, doctors and technicians to ensure an efficient response to treatments.
• Recruitment and retention teams set up by Government should be going out to high school students to attract youth to health professionals.
• Attract disaffected employees to return to work. If health care were better place to work, there may be a return of allied employees who quit due to their disagreement or dissatisfaction with the healthcare system.
• Subsidizing new students and forgiving student loans upon graduation and employment in the medical field will more than fill the void left by professionals leaving to the private sector.
• Training and honouring our health care practitioners should be much more important in our society than it currently is.
• Implement shorter shifts and lighter workloads to aide in retention of older nurses.
• Subsidize housing for all new practitioners.
• The children's hospital acute care facility is antiquated and the urgently needs rebuilding. It is imperative that we provide up to date facilities and competitive research opportunities in order to recruit these highly specialized professionals who come to us from around the world.
• Incentives such as scholarships and forgivable loans should be offered in return for five years practice in a remote location.
• Every region in British Columbia will need to develop its own recruitment strategy.
• Offer rural or isolation allowances to entice professionals to practice in remote locations.
• Increase the amount of General practitioners in British Columbia.
• Offer full-time pension contributions for those 55 years of age and who are working part-time.
• Increase the amount of permanent positions.
• Increase number of clinicians and life skill workers.
• British Columbia needs to stimulate new thinking to include males in nursing positions. Bring back job fairs at nursing schools for guaranteed job placement.
• Introduce candy stripers to provide small needs to patients as well as helping with feeding.
• Permanent nursing float pools in acute and residential care should be established in all health authorities. This would help the health regions to keep employees without losing them to the United States.

• Train and hire more homecare workers and pay them a decent wage for the tough job they are committing themselves to.

• Expand use of existing volunteer networks and offer financial support for these agencies.

• Develop recruitment tools aimed at ethno-cultural populations in rural areas so that they may serve the needs of those in their communities with a better understanding of those needs.

• Rurally trained professionals are more likely to practice within in their region of training. These professionals are also more likely to practice family medicine.

• Legislate all health professionals under terms of the Health Professionals Act.

• British Columbia is experiencing a shortage of doctors and nurses. Emergency ambulance crews are highly-trained and should expect some kind of security in their jobs.

• Implement a personal health navigator to ensure patients are receiving coordinated care at integrated health centers, looking at physical, emotional and psychological health.

• Have more than just researchers and lab technicians involved in caring for Phase-One clinical trial patients. Terminally ill patients are usually connected to community nurse and palliative care services in their home community. If their client opts to participate in a Phase-One clinical trial, those community services should connect their client with the equivalent services in Vancouver.

• There should be two main types of therapists; Clinical Psychologists and more narrowly-trained stream of therapists.

• With the exception of one central office, dieticians should be phased out. The remaining office would then be responsible for creating a dietician’s electronic database that would be available Province-wide.

• There is a need for a full time volunteer coordinator.

• Create a registry of community services in order to identify and fill and gaps in necessary human resources.
Midwifery should be better supported across British Columbia. Midwives practicing in northern British Columbia have the ability to admit women into hospitals. Women enjoy having the bond between a midwife and themselves in the pre and post-natal periods.

Create a registry of community services in order to identify and fill gaps in necessary human resources.

With the exception of one central office, dieticians should be phased out. The remaining office would then be responsible for creating a dietician’s electronic database that would be available province-wide.

**Ideas about public versus private demand:**

As long as doctors are working full-time treating patients, it should not matter whether they are in the public, private, or both systems.

I do not believe that doctors will flock from hospitals to the private facilities. I think they will work wherever there are interesting cases, as long as there is no huge disparity in the income. A heart surgeon or hip replacement specialist will stay within the public system if that is where those surgeries are.

A parallel private health system will at least keep health professionals in Canada.

Re-instate food and cleaning services to public sector positions.

By creating a public-private system that complements the needs of one-another, we can attract medical professionals to Canada and retain many of our own who would otherwise be heading to the United States.

Professionals should be allowed to work in either the public or private facilities. In the event of a conflict of interest, the public facilities will take precedence for service.

The Provincial Government controls the supply of professionals through its financing. When the budget is insufficient, nurses are laid-off or put on part-time hours and specialists are allowed only a limited number of operations. For example, an Orthopedic Surgeon finished his annual quota of operations earlier than expected; there is still an abundance of clients but he can practice no more until the next fiscal year. He should certainly be available to a private clinic for several months without affecting the public service.

Doctors have a moral obligation to provide universal health care.

The companies continue to make their profit and there is no other solution other than to bring the activities of these groups back into the public fold by paying appropriate wages and benefits.
• Private sector vacation time is dispersed throughout the year so as not to disrupt business. The Provincial Government should look at this model as one of the successes of the private sector.

• Any practitioner working in both the private and public sectors must provide at least fifty percent of their time to the public system.

• Address the current health human resource issues in some way that does not include privatization.

• Prohibit working in both public and private systems.

• Contract out all healthcare positions that do not involve direct patient care.

• Allow doctors the flexibility to operate within the public and private system. A practitioner could work two days a week in the public system, and three days in a private facility.

• Initially some health human resources will leave the public system to staff private clinics, but this will only occur in the early stages of the transitioning.

• **Ideas about education and training:**

  • Increase the amount of seats, instructors and practicum spots available to medical students.

  • Continue to expand British Columbia’s training capacity so that the Province can meet its current and projected human resource needs with the goal of being self-sufficient.

  • Health professionals should be educated right from the start that they will likely have five careers, all in healthcare, all.

  • Increase the number of residency training positions for Canadian medical graduates to a ratio of 1.2 positions per graduate.

  • Fast-track the development of training programs for Physician’s Assistants in British Columbia.

  • Place Nutritionists in public schools to address public health issues. Include speakers with emphysema to speak with students.

  • Increase perks and incentive instead of lowering the standards of education to bolster recruitment.

  • Increase the number of residency training positions specifically for International Medical Graduates from the current level of 18 in 2007 (12 GP and 6 specialty) to 40 by 2010, focusing on areas of greatest need.
• It is proven that professionals will usually stay within the region that they complete their practicum in. For example, Alberta will only allow Licensed Practical Nurses to complete their practicum within the province.

• Pair newly-graduated nurses with more experienced nurses to offer support and increase the amount of hands on, practical training.

• Create a system to train volunteers to assist medical staff with duties like feeding and running errands for the patients.

• The large amount of public money spent on overtime payouts would be better spent training and hiring new professionals.

• Utilize older and more senior staff to mentor new medical students within the hospitals.

• Increase training opportunities and funding for health science professionals.

• Apprenticeships help eliminate the shortage of trained personal.

• Create a mandate requiring newly trained professionals to practice within British Columbia for a pre-determined number of years, based on the subsidy level of their education.

• The Province must request its educational facilities to produce twice the number of professionals that are currently retiring per year.

• The only feasible way to counter the vacancies brought on by large numbers of retiring professionals will lay in the hiring of foreign trained professionals.

• Hospital training should offer a larger workload to interns. This would have the dual effect of increased hands on training for the student and less work for hospital staff.

• Nursing schools should return to hospitals. There, students would receive valuable hands-on training and address personnel shortages at the same time.

• Increase number of seats in post-secondary institutions.

• Grade 11 and 12 students should start in assisting in hospitals.

• Create a registry of long-term healthcare workers that have been convicted of abuse.

• There is a need for professionals with common sense, not just university degrees.

• Make midwifery an illegal practice.

• Address policies that block the hiring of more full-time personnel.

• List more alternative health care providers.
• Create a patient survey to determine what makes a good doctor. Create a list of best practices from this list and distribute openly to physicians.

• There is a need for more multi-cultural health care providers.

• There was a period in which midwifery was widely accepted. This period enjoyed shorter post-delivery hospital stays and a reduced demand on health practitioners during birth.

**Recruitment and Retention**

**Comments and Concerns**

- Recruitment and Retention of Physicians
- Recruitment and Retention of Nurses
- Aboriginal Representation within Healthcare Practices
- Region and Department Specific Demands
- General Comments on Recruitment and Retention

• Concerns and comments on the recruitment and retention of physicians:

  • British Columbia does have more general practitioners than the Canadian average but still fewer than almost every other developed country. Nevertheless, in 2004 89 percent of patients in British Columbia had a family doctor, the same percentage as in 1994, and higher than the Canadian average of 86 percent. However, there are concerns about the future supply of these physicians because an increasing number of newly graduated general practitioners are choosing to work shorter hours in walk-in clinics providing brief, episodic care. Complex health problems are difficult to address in these clinics as compared to more traditional medical offices where physicians get to know their patients and their patient's personal circumstances, sometimes over many years. The government has attempted to direct funding to more comprehensive care, but this measure may take some time to achieve results.

  • The shortage of General practitioners makes it extremely difficult for patients trying to find a family doctor that will accept them. Canada has fewer physicians per thousand citizens than most other developed countries, according to the Organization for Economic Co-operation and Development (OECD).

  • We do have a shortage of doctors in Canada, but one must bear in mind that a large percentage of doctors, half of all Orthopedic Surgeons, leave practice within five years of graduation because they cannot find placement within their field.

  • The aging of British Columbia’s practicing physicians represents a major concern as newer doctors are not working as many hours as their older colleagues. Younger
physicians are appropriately placing more emphasis on a balanced lifestyle. Subsequently, an aggressive recruitment and retention campaign will be needed to bridge the gap between training programs and service vacancies.

- Any conversation on health is worthless until there are enough physicians within the province allowing everyone equal care and access to a family doctor.

- Of the 30 highly-developed nations in the world, Canada ranks 26th for the number of physicians per capita. More than 3.6 million Canadians and 150,000 British Columbians do not have a family doctor. Some 20 percent of British Columbian General practitioners plan to retire or move within the next five years, and 80 percent are over the age of 40.

- It is almost impossible for a newcomer to this province to find a general practitioner that is accepting new patients. These individuals and families then rely on walk-in clinics or the emergency departments making the system more inefficient, both at the hospital level and at the clinic level, where it is unlikely that a patient will see the same doctor twice in a row.

- A patient is not always guaranteed access to a General practitioner, even through a walk-in clinic.

- There is a potential danger in drastically increasing the number of physicians in the country. In the late nineties both Germany and Italy had such an oversupply of physicians that Germany had thousands of doctors drawing unemployment insurance, and Italy had many surgeons who were performing one surgery every two weeks. A large increase in the number of physicians in BC will increase healthcare costs and make it more difficult to bring in reforms which may require fewer physicians.

- People are unable to obtain a regular family doctor because there is a shortage of family practitioners. However, the number of doctors required in the system does not just depend on numbers in relation to population. Other factors, including the practicing patterns of the doctors in the system, the way that they are utilized and organized and where they are located, matter as much as the numbers. In the Canadian health care system, individual physicians guide these factors to a large degree. For many years, thanks to the dedication of physicians who worked long hours, and who were willing to live, and practice traditional medicine in small towns as well as in urban and metropolitan areas, these individual choices did not greatly effect the effectiveness of the health care system. However, times have changed, the medical system has undergone some major changes in the past 16 years, and the individual choices of a number of physicians has led to thousands of Canadians being unable to find a regular family physician.
Before a General practitioner attends to a single patient, he or she must pay a full licensing fee and full Canadian Medical Protective Association fee. If he or she decides to slow down practice for a progressive retirement, their proportion of income will drop but their fixed costs increase.

British Columbia requires approximately 400 new physicians each year to replace those who are moving or retiring. Projections show a continued decline in the number of physicians per citizen as British Columbia’s population grows and ages. Even with expanded training levels, British Columbia is not keeping pace. Sixty percent of family physicians in British Columbia now either limit the number of new patients they see or do not take new patients at all.

Patients withhold information at walk-in clinics because they feel intimidated by their assessing physician. It is becoming increasingly difficult to find a family physician, and when one is found, they have so many patients that appointments cannot be made for one or two weeks. Patients go to walk in clinics or emergency rooms because they cannot wait a two week span to have their needs addressed.

The availability of general practitioners who have or request their hospital privileges has significantly decreased.

Around one third of Canada’s obstetricians will retire in the next five years.

The health care system is now seeing more women interested in being doctors and they are interested in a more balanced lifestyle. It is not hard to imagine why British Columbia is having trouble attracting general practitioners because they have the banker’s hours of Monday to Friday, eight am to five pm.

The gender distribution of practicing physicians has changed dramatically over the years. Currently, more then 50% of medical graduates are females who may elect at some point in their career to limit their practice to start and/or raise their families. There have also been changes in the personal priorities of physicians generally, recognizing the need to balance work and family life.

Concerns and comments on the recruitment and retention of nurses:

One third of British Columbia’s pediatric nurses are poised for retirement.

One third of nurses leave their profession in the first five years due to their high levels of stress.

There is no problem getting people into undergraduate nursing programs, the challenge lay in retaining them for five years after they have graduated, after they realize that the field of nursing will not live up to their expectations.

Emergency room nurse retention levels are a concern.
• There are no positive images of nurses in our society. Male students with a good grade point average would never be encouraged to be a nurse yet it is an exciting, challenging, adequate paying, flexible and global career.

• The closing of hospital beds disrupted many nursing careers. Many now rush around between several part-time positions in order to receive full-time pay, resulting in more stress on practitioners and poorer service given patients.

• Nurse Practitioners will be in very high demand as the need for health care professionals exceeds current graduation levels.

• Removing charge nurses from the system may have created a short-term financial gain, the rest of the nursing staff are now burdened with a heavier workload.

• British Columbia has lost many nurses by putting them on call, excluding employers from paying benefits. These nurses took up other professions that better appreciated their skills; the Province is now suffering the consequences.

• The Organization for Economic Cooperation and Development (OECD) predicts that by 2016, Canada will have the most severe of all OECD nations, with a shortfall of up to 31 percent compared with demand.

• A goal of the Health Authorities has been to significantly build up the number of residential care beds. However a nurse is required to service that bed and with two-thousand present nurse vacancies, this initiative poses a serious problem.

• Nurses trained with a geriatric focus or certifications are short in numbers.

• The recent pay raises granted Members of the Legislative Assembly would have been better utilized by hiring more nurses.

• **Concerns and comments on Aboriginal representation within healthcare practitioners:**

  Aboriginal peoples constitute only 0.6 per cent of the nursing workforce, 0.1 per cent of the dental workforce, 0.2 per cent of medical practitioners, and 1.1 per cent of health services managers.

• Most of the doctors working within Aboriginal communities are not from Aboriginal ancestry or background.

• **Comments on region and department-specific demands:**

  Emergency rooms lack emergency specialists.

  While the budget for British Columbia Ambulance Service has increased, the resources on the street have not kept up to the increase in demand for services.
• Summer long-weekends prove to be a very dangerous time to be admitted into a hospital as consultative and specialist staff are often unavailable or on holiday.

• New graduate nurses at the Royal Inland Hospital are lucky to get a long enough orientation let alone a signing bonus.

• The Interior Health Authority eliminated many of their Registered Nurses and is now probably paying more out in overtime and to travel nurses to fill the facilities with casual employees.

• Victoria is in great need for general practitioners.

• Okanagan medical service staff are leaving their practices in large numbers for employment elsewhere.

• Providing staff coverage for Vancouver Island intensive care units in the summer is challenging due to funding changes instituted by the Vancouver Island Health Authority.

• There are no local health care nurses in the Tofino area. There is also little in the way of housing or support for these health professionals as rent prices are very high.

• The town of Lytton cannot fully staff their health care centre.

• There is little incentive drawing practitioners to the Sunshine Coast.

• A local hospital has been forced to close their Intensive Care Unit numerous times because of no staff.

• The recruiting center for Northern British Columbia is currently located in Prince George where they hire health professionals for all the major centers and leave nothing for the remote rural communities.

• Increase the use of traveling specialists; only five visit Smithers on a frequent basis.

• There is a shortage of Registered Nurses in Northern British Columbia.

• Many health professionals tend to gravitate to the larger urban centers to be on the cutting edge of medicine.

• The city of Chase lacks physicians.

• The Royal Jubilee hospital in Victoria often lacks the necessary staff to perform renal dialysis procedures.

• Gabriola Island has a population of 4500 and three physicians with which to serve them. There is no after hours service other than an ambulance which simply transports people to hospital rather than treating problems in the community.

• One of the challenges that face the more remote communities is retention of health professionals. There seems to be little issue with attraction however physicians want
the opportunity to hone their skills. With small populations to practice on, they are not feeling they get to practice as much as they would ultimately desire.

- The Province, particularly Vancouver Island, is dramatically short of cardiologists.
- There are six over-worked pathologists in all of Vancouver that provide autopsies for Vancouver, the Yukon, and the Islands.
- Many First Nations communities and reserves critically lack doctors and nurses.
- Other provincial authorities are sending letters offering money training, and job placement for spouses to nursing graduates at Thomson Rivers University.
- Forensic psychiatry is offered by only one clinic in rural British Columbia. This clinic is responsible for serving the entire region between Hope and Clinton.
- It is clear that after six years of unsuccessful searching in Kamloops, Penticton, Kelowna and Surrey for a doctor accepting new patients that medical services are not being made available to all, but rather to those who can afford to go elsewhere for them.
- When I go to the Mary Pack centre for treatments, it is clear that the warm pool and physiotherapy tables are being underutilized due to lack of staff.
- The severe nursing shortage has forced the closure of an operating room in Vernon. This put an immense amount of pressure on the remaining nursing staff and left a newly recruited anesthesiologist out of work. The solution was to put more pressure on the nurse manager of the operating room staff, who is already under immense pressure to reopen the closed operating room.
- Ever since the Northern Health Authority laid-off many of their experienced maintenance personnel, the quality of and quantity of maintenance duties has suffered.
- Intensive care units are extremely understaffed, requiring nurses to call for outside assistance.
- There is a need to examine sick time and staffing levels across the province.
- Keremeos is suffering from a shortage of physicians.
- Doctors have a monopoly on providing services in emergency.
- What is the reasoning behind the staffing of emergency rooms mainly during the day? Clinics and General practitioners are openly available so why short-staff an emergency room at night?
- I am very concerned with the staffing ratios in Residential Care Facilities. More staff is needed in order to provide dignified care for the elderly. By more staff I am
referring to care aides. I know a certain amount of time is dedicated to each resident but different amounts of time are needed for each individual. Unless you have actually practiced this type of care, the math only works on paper and not in the real world. As it stands now, each care aide has between 10 to 11 residents to care for on a day shift, between 13 to 15 on an evening shift and 29 to 30 on a night shift. The bottom line is more care aides are needed not more management.

- There are secretaries working for secretaries with one job function for an entire day when there are only three part time cleaners for an entire hospital, and only two are available on the weekend.
- Specialty areas like Computerized Axial Tomography (CAT) have very few staff but are critical to timely and adequate care.
- There is no ward doctor or Nurse Practitioner assigned to post surgical units who can prescribe changes to medication regimes.

General comments on recruitment and retention:

- British Columbians expressed concern over a shortage of professionals in virtually all fields of practice.
- The College of Physicians and Surgeons is not responsible for the recruitment of physician human resources and cannot provide appropriately licensed physicians upon request.
- The regional health authorities are unable to recruit and retain financial and administrative staff.
- From 2001 to 2005, the total number of physicians in British Columbia increased by five percent; however, the ratio of physicians per population increased only by half a percent. Even with expanded training, physician supply in British Columbia is not keeping pace with population growth and aging. Between 1994 and 2001, the number of Registered Nurses per 10,000 residents declined from 74 to 68. This is the lowest nurse-to-population ratio in Canada. In 2005, the average age of a nurse in British Columbia was 46.4 years, 1.7 years older than the national average. In British Columbia, Registered Nurses aged 50 and older represented almost 40 percent of the 2003 workforce. In 2005, 47 percent of British Columbian physicians were 50 years or older, with 17 percent of them over age 60. 52 percent of British Columbian specialists were aged 50 years or older, while 43 percent of family physicians were aged 50 years or older. The number of General practitioners in British Columbia who are accepting new patients declined by almost 70 percent between 1999 and 2006 while the province’s population grew by 7.5 percent.
• Early intervention programs lack trained specialists like Occupational Therapists and Physiotherapists and premature babies are not getting the intervention treatment they require.

• Young people coming on stream now have much different mind-sets and values than those who are designing the system. If there is no effort to connect with the values of the younger generation than any recruiting effort will be a waste of time.

• There are not enough doctors and support workers to provide early intervention services for seniors.

• There is a lack in general access to Physiotherapy, Occupational Therapy, and recreation therapy.

• One-half of part-time and one-third of full time Pediatric physiotherapists will retire in the next five years.

• There is a shortage of child psychiatrists, which is resulting in many children and adolescents being unable to access specialty care.

• There are retention issues in the finance department of health.

• Grade schools lack recruitment and information regarding various health fields.

• The United Kingdom, along with many other countries and provinces, are actively recruiting Canadian Registered Nurses.

• The current system lacks incentives like signing bonuses when hiring new professionals.

• The availability of quality childcare is a critical recruitment and retention issue. Young people are dramatically impacted by the diminishing number of quality childcare spaces and unless health care comes to grips with that, there are going to be tremendous difficulties on the recruitment and retention front, regardless of how successfully we deal with other issues.

• Recruitment of health care professionals in British Columbia will continue to be a challenge as long as the model focuses on illness and disease instead of wellness and health.

• There are physical limits as to how much volunteers really can do to help.

• A greater use of volunteer services will result in a net loss in health care positions.

• There is a general lack of respect for volunteers and their services.

**Ideas and Suggestions**

[Recruitment and Retention of Physicians](#)
Ideas about the recruitment and retention of physicians:

- Create and circulate a list of physicians practicing within British Columbia.
- Hospital physicians should be on staff 24 hours a day, seven days a week in order to discharge patients during evenings and on weekends.
- Regular access to a family physician would expedite the diagnosis of chronic diseases and allow health professionals to address them earlier.
- The Health Authorities along with advisory input from the College of Physicians and Surgeons should hire doctors and the Provincial or Territorial Governments should be the ones to grant licenses.
- Doctors should be under the direct supervision of an employer and must be working full-time equivalency in order to serve the public, whose tax dollars helped in the subsidy of their educations.
- Allow physicians to operate in a more mobile function between facilities in major urban centres.
- Introduce the role of the physician’s assistant to ease the burden on the doctor.
- Have Homeopathic and Naturopathic Doctors included as point of access equal to that of a general practitioner.
- Find ways of getting family doctors to spend more time with their patients.
- The Ministry of Health should assign a personal physician to a Phase-One clinical trial patient upon their arrival in Vancouver. The Province could add that cost to the contract negotiated with the pharmaceutical company leading the clinical trail.
- Pediatric specialists such as neurology, orthopedics, and psychiatry are required on an outreach basis.
- If physicians were bound to the duties they were trained for, there would be more available doctors and fewer patients lacking a family physician.
- Each and every British Columbian should have a Family Physician.
- Consider implementing three practicing levels of doctor; specialists, general practitioners and junior doctors; responsible for treating simple medical illnesses. The junior doctor would complete two years of training on top of what is required for senior nurses. The pay scale would be higher than that of a Registered Nurse and lower than that of a Medical Doctor.
• **Ideas about the recruitment and retention of nurses:**

• Hire nurses back into Northern British Columbia with incentive programs.

• We need to show images of what nursing is really like, how rewarding it is and how diverse it is. We need to encourage young people to consider it as an excellent career opportunity in that you can set your own hours and travel the world. Nurses change people's lives and save lives too.

• Re-instate the head nurse within hospital wards.

• There is a need for home care nurses who have the skills and training to assist the elderly.

• The long delays caused by the College of Nurses when hiring a foreign trained Registered Nurse should not be a problem as operating room scrub technicians belong to a different governing body. This would consist of a cost savings and enable British Columbia to provide added services to the community, thus shortening wait lists.

• Hire and train more Licensed Practical Nurses and decrease the reliance on Registered Nurses as they are cheaper and faster to produce.

• Place Nurse Practitioners in community run walk-in-clinics, such as the Centre Local de Services Communautaires in Quebec.

• Hospitals must implement an aggressive recruitment program aimed at getting nursing numbers up to more acceptable levels.

• Place more Nurse Practitioners in emergency rooms to relieve the pressure on doctors and ambulance crew.

• Nurses should work full time positions instead of the majority of them working three part time jobs.

• California and Australia implemented set ratios of nurses to patients. This led to a dramatic increase in the number of Registered Nurses available for work because many who had left the profession came back, attracted by the prospect of manageable patient loads. While government and health care employers may fear that implementing nurse-to-patient ratios could force the closure of services during a nursing shortage, real-world application has proven otherwise. These ratios should be set by the Registered Nurses themselves in order to properly control their workloads.

• Hire social workers instead of nurses for jobs requiring an experienced social worker; for example geriatric emergency nurses at some Vancouver hospitals could easily be replaced by social workers, helping deal with the nursing shortages.
• Registered Nurses are highly skilled in administering shots and performing certain treatments, therefore they should be staffing clinics in support of physicians.
• Increase the amount of practicing street nurses in small urban and rural communities.
• There is no need for head nurses in long-term care facilities.
• Provide the patient more access to Nurse Practitioners for minor problems.
• Cleaning is not within the nurse’s scope of practice. There should be more effort to hire the proper support staff to take this burden of nurses.
• Gerontologists and nurse clinicians are needed in emergency, long term care, and in primary care clinics.
• Implement a nurse responsible for palliative care service co-ordination.
• Legislate the position of a triage nurse in emergency rooms. They would have the authority to send cases away to clinics if necessary.
• Some staff hold positions that they are not qualified for; clerks are overseeing Registered Nurses and making decisions without full knowledge and consultation on situations.
• Use operating room technicians to assist in operating rooms to alleviate the pressure on surgical Registered Nurses.
• Utilize Licensed Practical Nurses and Registered Care Aides to their full scopes of practice to help alleviate Registered Nurses workloads.
• Allow Nurse Practitioners to take over some of the more complex patients from doctors.
• There is a need for nurse clinicians in doctors’ offices to screen charts to ensure test results prior to seeing doctor.
• Expand the role, raise the pay, and offer new dress to Nurse Practitioners. These new Nurse Practitioners would staff walk-in clinics and compete to take some of the pressure off of doctors.
• Hire more Registered Nurses to monitor hallway patients.
• Increase the roles of the public health nurse to include preventative services.
• Promote the utilization of Licensed Practical Nurses in every British Columbian community as such a move would decrease the pressures placed on doctors.
• Nurses should triage emergency rooms and Nurse Practitioners should be the first line of care.
• Offer nurses incentive to remain in a full-time position in a specific ward with cash bonuses after every six months, extra time off with pay, registered retirement savings plan lump sum deposits and more access to educational opportunities. Show them they are an important part of the health care system and ensure that administration hears their voices by improving access to collaborative brainstorming and support sessions.

• **Ideas about Aboriginal representation in the healthcare sector:**
  - Recognize Aboriginal health team members and their contributions to bridge the gaps in health human resource planning.
  - Expand the role and implementation of the First Nations health liaison officer.
  - Increasing the number of Aboriginal health care practitioners is a priority and this should include:
    - Adequate resourcing;
    - Setting targets for training;
    - Developing programs to attract Aboriginal health care practitioners to remote areas;
    - Linking secondary and post secondary education avenues; and,
    - Expanding e-health and tele-health initiatives.
  - Aboriginal expertise must be consulted with when hiring, training, and making decisions such as traditional health accreditation.
  - Aboriginal nurses must be included and retained within the partitioning health field.
  - Implement First Nation liaisons in hospitals to increase communication for discharge planning and home care
  - The Saskatchewan Association of Health Organizations considers the First Nations population as possessing a large number of young, potential health professionals. British Columbia should be investigating the same possibilities.
  - The federal government must support first nations nursing.
  - Offer First Nations graduates bonuses to return and practice within their communities.
  - First Nations youth must be encouraged to enter into occupations in the healthcare field.

• **Ideas about regional and department-specific demands:**
  - The British Columbia Cancer Agency requires a Pediatric Anesthesiologist on their staff.
• British Columbia does have many new medical graduates and is often finding placement for these new professionals in Northern British Columbia.

• A requirement for Physicians completing their practicum should be a certain amount of practice outside of Victoria or the lower mainland.

• Place doctors and specialists from outlying rural communities back in the local hospital.

• Attract more emergency room physicians, general practitioners, and other allied health professionals to the coast by improving diagnostic and treatment equipment and supporting affordable housing for professionals.

• The Provincial Government should look at forgiving student loans to those who commit to practice in a rural setting for a period of time.

• Increase access to mental health and addictions services in Northern British Columbia.

• Create a team of traveling specialists who can be flown to anywhere in the province on a moments notice.

• Place a security guard at the entrances to emergency rooms.

• Adequately staff health care teams practicing on British Columbia’s populated islands.

• Northern hospitals require more volunteers and staff to be able to assist patients with mobility issues.

• Northern health service providers should be able to rely on technologies such as tele-communication and a greater use of e-tools such as power chart, electronic medical records, and video conferencing.

• Utilize ambulance crews in a more efficient manner; they should be picking up patients and saving lives rather than sitting in emergency departments awaiting the admission of their patients.

• Create or increase Northern allowances to attract professionals trained in mental health and addiction counselling services.

• British Columbia’s metropolitan citizens have access to world-class health care.

• Ensure optical surgeons are available to regions of British Columbia.

• Northern British Columbia requires an outreach Pediatric Psychiatrist.

• Clinics that cater solely to long-term chronic disease are in need of trained specialist staff.
• Place an enterostomal therapy nurse in an Okanagan hospital, which can help deal with ostomy issues.

• Although Dawson Creek requires the services of a radiologist, however these services can be delivered by a practitioner in the lower mainland using e-communication tools.

• The Matsqui-Sumas-Abbotsford general hospital must increase their capacity to offer psychiatric services to their patients.

• Rotate staff through urgent care and emergency rooms to decrease burnout.

• Increase staff at known times of increased utilization such as long weekends and during the summer months.

• Mandate better use of Physiotherapists and Occupational Therapists in residential care units.

• Long-term care facilities require more staff to address the needs of their residents in a more efficient manner.

• Have Naturopathic Doctors on staff at hospitals.

• Emergency departments require and increased in the number of staff on hand over weekends and holidays.

• The British Columbia Cancer Agency needs a child Anesthesiologist on staff.

• By properly allocating human resources, the Province could staff extra beds. One Nurse Practitioner could run an entire ward filled with geriatric overflow if Licensed Practical Nurses and Registered Care Aides were hired to work under his or her guidance.

• Open operating rooms 24 hours a day, seven days a week so they may by better utilized to address the wait lists.

• The hospitals themselves must hire cleaning and kitchen staff in order to ensure fair pay.

• There should be more social workers or advocates trained to listen and try to settle people down when they arrive at emergency confused and scared; thus freeing nurses from dealing with this mundane task.

• Eliminate the positions held by Hospitalists and employ dedicated staff doctors.

• Cancer centres would benefit from a patient and family counseling department.

• Hospitals must increase the number of physiotherapists available to all departments.
• More long-term staff are required to reduce the time to respond to the needs of long-term care residents.

• There is an acute need for trained mental health workers in all aspects of health care.

• **General ideas about recruitment and retention:**
  
  Money may not be the only factor in attracting a good working force to any organization. Other important factors in recruitment and retention of health professionals are:

  o Stability of work;
  o Congenial working environment;
  o Adequate holidays well covered by available locum;
  o Continuing education & research opportunities;
  o Recognition of excellence; and,
  o The chance for promotion.

• There is a need for a full time volunteer coordinator.

• Hire enough staff to properly clean and sanitize hospitals.

• Staff do not need to receive bonuses at year end but free parking or flexible start times, or even an earned day off could be used as incentive to stay at a job.

• By allowing younger persons to volunteer in hospitals, we may be stimulating an early interest in an occupation in the health care field.

• Rotate doctors from cities and rural areas. Both can learn from the experience and both can realize what the other is up against.

• Allow professionals more recognition, flexibility, the opportunity to train and mentor new staff, and the opportunity to learn new skills. Apart from being burnt-out and demoralized, hospital staff prefers to stay in the sector. Ask them what it would take to keep them within the system.

• To improve the work environment, an effort must be made to initiate more flexible work models for health care providers at different ages and stages of their lives.

• Reserve housing neighboring hospitals for health professionals and their families. This would be especially beneficial for the recruitment and retention of staff in rural areas.

• First and foremost we must recruit and retain family doctors with long term lucrative contracts for both the doctor & the health authority, maybe by using peer to peer recruiting.
• The health care system must attract, train, and compensate care aides to enable seniors to age in their homes.

• British Columbia has many isolated, yet populated islands requiring the service of Nurse Practitioners, Physiotherapists and Occupational Therapists.

• The education system must respond to the health human resource shortages by providing a greater emphasis on completion of high school, a focus on science-based education, an orientation to university education, and the capabilities of local students to achieve professional levels of education. A component of this could be greater mentoring from local professionals and visitations from former residents of rural communities who have achieved such educational and professional goals.

• Increase the amount of practicing midwives in British Columbia.

• Job redundancy is becoming more common, thus an effort to cap the amount of practitioners in these jobs is needed.

**Leadership, Administration and Management**

**Comments and Concerns**

*Staff Scheduling*

*Remuneration*

*Healthcare Administration*

• **Comments on staff scheduling:**
  
  • What kind of service can you expect from a medical team that has been at work for almost twelve hours? It is silly to believe that the average doctor or nurse is delivering good patient care after eight hours on-duty. What is efficient about a system that encourages long hours of unproductive work?

  • Surgeons and anesthetists are not available around the clock.

  • Staff shortages should not be attributed to a lack of workers, rather they are due to wasteful allocation of employee hours and triple over-time.

  • Nurses with families are finding it difficult to maintain their credentials due to the inflexibility of their scheduling.

  • Primary care physicians are working short weeks in order to maintain a decent work-life balance. Unfortunately this means that patients cannot access their doctors in a timely manner.
• Doctors may not want to work the hours that they have in the past such as one week on followed by one week off.

• A nurse working a shift on a long statutory weekend can earn approximately the equivalent of one full week of day shifts. This is possible due to lucrative stat holiday pay, shift differential and weekend pay. If the nurse should not finish work on time and requires overtime, the hourly rate increases phenomenally yet again.

• Within home support staff, there is a growing trend to utilize casual hours or split shifts, which means community health workers must be available within a ten hour window, but often end up working and getting paid for a few hours in the morning and a few in the afternoon with nothing in between.

• Emergency room nurses are overworked, putting in extremely long hours with no choice.

• **Comments on the remuneration of health professionals:**

  • The problem is not a shortage of human resources but poor allocation of money with which to pay them.

  • Publicly employed and unionized cleaning and cooking staff were compensated much more generously than private sector staff.

  • Why would a paramedic in their right mind want to receive twenty dollars of pay for a ten hour shift when they could have made many times that working another job.

  • The Health Employers Association of British Columbia has created a huge gap in wages between Registered Nurses and other specialized health professions such as Respiratory Therapists. This discrepancy will increase to seven dollars and hour by the end of the current contract. How does the Provincial Government plan to attract new students into respiratory therapy when they are treated as second class professionals?

  • A Specialist will earn up to forty per cent than a family physician per annum.

  • Simple economics dictate the shortage of doctors in Canada. Those within the system benefit from a shortage of doctors. The less available doctors are, the more visits are required per doctor, equaling a better income for these doctors.

  • There is little doubt that the new generation of health care employees will demand and receive higher wages and better benefits. Those costs will be higher if we do not begin to train larger groups of professionals.

  • A physician willing to enter geriatric medicine will encounter too many financial disincentives to even begin practice.
In the past, addressing rural health human resource planning came down to just paying more to those who choose to practice in the communities. What we continually hear from people now is that it is about the money anymore. Most healthcare professionals are practicing their high level of skill, they are reasonably well paid and they possess good technical jobs. An extra five percent over two years is not going to make them happy people. These rurally operating practicing professionals are just incredibly unhappy on the frontlines.

- Doctors are only allowed to bill one visit per patient per day
- The current physician remuneration structure is not conducive to employing duty doctors.
- The fee-for-service model limits the amount of time a physician can spend with their patients.
- The generous pay-outs and severance packages to management staff are an unacceptable waste of taxpayer monies.

• Comments on healthcare administration:

  - The current health care system is burdened by an excessive amount of administration.
  - How can the current administration say that healthcare is working well and at the same time implement layoffs of highly skilled practitioners?
  - There seems to have been a rapid increase in the number of middle management positions that often overlap and have no tangible or measurable impact on the delivery of health services. These positions have also led to the removal of many talented nurses and technicians from the front-lines.
  - Some staff are being promoted rapidly into high-level leadership roles, yet they possess no proper skills.
  - Healthcare lacks the training regimes required for employees transitioning into managerial roles.
  - We do not need more managers and administrators as those that we have need to do more than socialize. They need to manage and make decisions.
  - Health administration responsibilities have moved to business representatives with good resumes.
Ideas and suggestions

Staff hours and Scheduling
Remuneration
Healthcare Administration

Ideas about staff hours and scheduling:

• Occupational Therapists and Physiotherapists must work more than Monday to Friday, 8:00am - 4:00pm.
• The system does not work well without part time staff. Part time staff afford a degree of flexibility to accommodate seasonal and other variables in workload requirements. Full time positions do not allow for reduction in working hours.
• Regular and predictable hours are required to recruit and retain qualified community health workers.
• Allow employees to set their own schedules as self scheduling allows flexibility and more room to schedule work around other commitments.
• Hospitals should require staff to work no more than eight hours at a time.
• If the agreed Government employee work week is 35 or 37.5 hours, overtime should not be paid until this weekly allotment of hours has been achieved.
• An effort must be made to end the excessive overtime hours required of British Columbia’s health professionals.
• Both management and the unions need to offer more flexibility in scheduling such as increasing the use of split shifts.
• The Provincial Government must work collaboratively with other public institutions to create permanent, full-time positions for health care personnel.
• Doctors, especially emergency room physicians and interns should work no more then 12 consecutive hours and have a rest period that matches their working hours; for example if a physician works ten hours, they must then rest for ten hours before they can practice again.
• I am quite shocked that nurses are required to extremely long shifts. Arrange their shifts so that they are more sensitive to the sleep patterns and the needs of a person's body.
• Hire more staff and utilize them on a 24-hour schedule not 12 hour schedule.
• Scheduling for premium shifts such as statutory weekends and holidays should not be available to those working only for their own personal gain.
• Staff may be taking two hour lunch breaks and one hour coffee breaks due to the nature of extremely long shift scheduling.
• The nurses should only work nine hour shifts with a one hour overlap to relay information to the new shift.
• Increase the amount of full-time or permanent part-time positions; doing so will rebuild health care teams, stable workplaces, and decrease the fragmented care given by tired part-time workers working in between facilities for full time equivalency.
• Some staff are required to put in extremely long hours, while others cannot seem to get enough hours. A formal appeal process is necessary for these types of incurrence's along with a high-level supervisor to delegate hours fairly.
• Ensure that family caregivers are given time off that is paid for by the Government.
• Health authority management should have their holidays cancelled and be required to assist care facilities that are under-staffed during traditional holidays.

• **Ideas about remuneration:**
  • Compensate general practitioners for specialized health care instead of forcing them to refer many patients to specialists.
  • Raise nurses’ salaries to create more interest in the profession.
  • Pay doctors and nurses better for their excellent service.
  • In return for subsidized training, British Columbian physicians should be required to practice for at least five years at a substantially lower rate of pay.
  • New doctors need a salaried employment, effectively bringing an end to the doctoral monopoly and more focus towards a multi-disciplinary clinic-environment.
  • European countries have historically produced more medical doctors per capita than we have, and they pay them less.
  • Physician billing based on a fee-for-service basis, has changed how a physician attends to a patient. Salaried physicians would decrease the amount of extra money billed for on explorative procedures.
  • All doctors should be employed directly by the Health Authorities.
  • Address the pay inequities for personal care aides working as home support workers.
• There are too many specialists and not enough family physicians. Family Practice could be encouraged through higher salaried remuneration.

• Support staff must receive adequate pay and benefits to insure proper staffing for home support and assisted living.

• Caregivers require adequate financial coverage for the cost of their supplies.

• It would be advantageous if fee guidelines provided incentive to Family Physicians for early recognition or early diagnosis and provision of care to people affected by dementia.

• Create a system that grants pay raises to all practicing health care professionals instead of individual practitioners. Under that same system, cutting pay would require universal cuts in salary, so that no one practice or practitioner is singled out.

• **Ideas about healthcare administration:**
  
  • Internal promotion of administrative staff is much better than tendering expensive contacts to private sector individuals.

  • Implement an independent audit to determine the number of peripheral administration staff compared to front-line workers.

  • The Provincial Government must reduce the amount of administrative personnel in the health authorities and turn the savings over to the front lines by offering more permanent positions. An increase in .5, .7 and .8 positions to Registered Nurses and Licensed Practical Nurses, with greater flexibility in their shift rotations.

  • Ensuring that administration is granted flexible scheduling will help in addressing the shortages and poor retention.

  • Hire people who have proven themselves in the business world to run British Columbia's hospitals as most academics tend to be idealistic and impractical.

  • Professional administrators are required in hospitals to ensure that everyone is doing their job to the best of their ability and in an organized manner.

  • Do away with the upper-level lawyers and bureaucrats in the system today. Offer more authority and control to the front-line employees. This would both reduce staffing costs and increase the operational efficacy of the health care system.

  • Lay off around fifty percent of the administration of health care.

  • There is a need for strong front line leadership and reasonable span of authority to ensure success at operational level.
• Medically trained personnel want their superiors to possess medical training of some sort.

• Have hospital administrators and executives work at least one day and one night shift a month in the areas they are responsible for. Have them buddy with any of the health care workers they should be answerable to.

• Increase the amount of front-line supervision to discipline and support front-line workers. Have designated duties at designated times. Have a floor supervisor who supervises all aspects of care from janitor to nurse.

• Invest time and money in leadership development which helps retain staff and improve morale.

• Offer site managers orientations for consistency.

• Get rid of the dead weight on top and use that money to put into the people who actually do the physical work with the residents you could make a big impact in the health care system.

• At the unit level you need someone who brings leadership and management, because leadership is about having vision, and if you are looking at how practice should unfold, there needs to be somebody there who's got the capacity to articulate that vision and inspire the staff on the unit to achieve that vision, but you also have to have some of those management skills

Labour Relations

Comments and Concerns

Collective Bargaining
Unions and Professional Associations
Essential Services

• Comments on collective bargaining:

  • Labour codes are affecting private contract work.

  • Too much health policy is negotiated into the context of a collective agreement.

  • Collective agreements place restrictions on some practitioners’ ability to do their jobs.

  • The Provincial Collective Agreement of April 2006 was forced upon nurses.

  • Governments, employers and unions are always in a state of conflict. Governments and employers want to cut the number of union members who are
delivering services and it all comes down to saving money and lowering the quality of care.

- There is little time for re-negotiations.
- Our worth has not been acknowledged through collective bargaining and we have been walled in.
- Long-term contracts are only valid for one year.
- Collective agreements are forcing nurses to work overtime.
- Interior Health Authority employees may not speak publicly about their work environment unless approved, and subsequently fear losing their jobs if they speak out. Physicians can speak publicly because they are not Interior Health Authority employees. As a result, the public believe that nurses have no complaints.
- Those working in healthcare have no motivation to change the system due to a conflict of interest. Process improvements and efficiencies might mean a loss of jobs.
- High wages, high benefit packages and strict guidelines on job descriptions create cutbacks in other services.
- A successful business would never treat its employees the way that the healthcare system treats its workers. There is a disregard for contracts, unsafe, unhealthy, and unproductive work hours, planned avoidance of benefits and generally adversarial treatment of health care workers in all sectors.
- Labour agreements offer relative stability and some opportunity for planning.
- Most people believe in the fairness of collective bargaining and the right to earn a wage that can support a family.
- The nature of contracts between doctors and the Medical Services Plan needs to be reassessed.
- Introducing competition requires public-sector employees to be more accountable for costs and quality of the work they perform.
- Being held accountable does not always inspire cooperation in the public sector; more often, it stirs up hostilities.
- A large portion of hospital costs are associated with compensation packages.
- In a system where people are covered by a labour agreement and only have to sign in as to when they start and end work, there is potential for abuse.
• **Comments on unions and professional associations:**

  • We have a heavily unionized workforce with too many processes and paper work.
  • The gatekeepers of healthcare are self-employed and have vested interests.
  • The British Columbia Medical Association is a very strong union and lobby group. They serve their members and control the health care system.
  • Shift work and long shifts are affecting quality of patient care and are not cost effective. Nursing unions fought for the twelve hour shift, but perhaps this position needs to be re-visited.
  • Restrictive work practices protect union jobs but ruin productivity.
  • Unionized employees in hospitals have very light workloads.
  • Unionized employees are safe even if they are not doing a satisfactory job or treating patients poorly.
  • Unions are cutting off volunteers such as candy stripers and outpatient aides.
  • Unions are afraid of losing membership and control over the delivery of health care in British Columbia.
  • Unions use fear tactics and smear campaigns to lobby British Columbians into believing that private care is a vice of greed, as opposed to a model of efficiency.
  • Unions control the debate on health care spending and reform.
  • British Columbia is heading in the direction of a health care crisis, with an aging population and powerful unions that are reticent to change.
  • There is a climate of confrontation within trade unions.
  • Contracting out is an attack on unions.
  • The British Columbia Nurses’ Union will not let nurses work part time; they insist that they be paid full-time benefits. Even teachers do not have this right.
  • Nobody has the courage to take on the unions.
  • Employees who do outstanding work are not being properly encouraged or recognized.
  • The only people who do not want more private involvement in the delivery of healthcare are the unions.
  • Public sector unions have a major influence on the system, raising loud protests whenever any improvements are proposed.
· The unions are too strong in British Columbia. Managers are unable to manage because they are afraid of the unions. There is no accountability for most health care workers.

· Government unions that strike are in the wrong. They are paid very well and have benefits and pensions. They are being paid more than they are worth.

· There is a problem with unions concerning seniority and work schedules. There are nurses who are willing to work, but not the schedule they have been offered.

· The British Columbia Medical Association is acting more like a union than an advocate for system improvements.

· Unions will cooperate if things are restructured and there is authentic participation where people relinquish some control.

· The number one problem in health care in British Columbia is the Health Employees Union, the British Columbia Nurses’ Union and the BC Medical Association. These special interest groups control and manipulate the health care agenda in British Columbia.

· Unions control the medical system. In a professional area such as health care, it should be an option to join the union.

· The unions are dictating public policy and how health care is delivered.

· When there is a union, prices cannot be controlled.

· Unions have too much power; nurses are not disciplined when they are not fulfilling their job description.

· Too much money is wasted while the public is being manipulated by the unions.

· The unions do not want a change and that is why the system is inefficient.

· There are empty beds in hospitals that are waiting for someone in the proper union to clean them.

· Unionized workers who work beyond their requirements are reprimanded by the unions.

· Unions are holding the health care system hostage, and necessary changes cannot be made as a result.

· The high price of labour unions is one of the most costly parts of our health care system.

· Private clinics are able to provide efficient and accountable health care. Workers are proud to work there and deliver quality care. This is because there is no union.

· Some of the union-related issues are not as complicated as we might think.
• Fee-for-service rewards quantity over quality, and is unfair to the patient and the health care provider.

• The British Columbia Medical Association has too much power. It has placed too many limits on cost-efficient options like midwifery, pharmacists being able to distribute prescriptions and expanding the responsibilities for Nurse Practitioners and paramedics.

• The proposed governance structure for the College of Dental Surgeons does not allow for Certified Dental Assistants to have a voice in the future of their profession. Certified Dental Assistants are appointed by the College of Dental Surgeons of British Columbia, and not elected by the constituency that they represent.

• The British Columbia Medical Association (BCMA) has a vested interest in not improving the system and maintaining the inefficient status quo.

• The basic problem with the health care system is that it does not focus on health. The College of Physicians and Surgeons have a monopoly on public health care dollars. They have joined forces with the pharmaceutical companies and the focus is on making money.

• There is no professional link between Licensed Practical Nurses and Registered Nurses, which is a major problem. Their interests are in conflict.

• The Canadian Medical Protective Association is putting physicians in a place where they do not feel they can engage other professionals regarding insurance liability because of the risks they are assuming.

• The Canadian Medical Protective Association is an amoral organization that suppresses the injustices committed by their members, and is protected from legal action taken against them.

• It is organized labour that protests private health care. This may be due to private facilities not being unionized, and organized labour losing membership as a result.

• Unions lobby for their own interests and not for those of the general public. Their arguments are based on employee rights rather then patient needs.

• Physicians go to school for many years to learn how to diagnose and treat patients. It is unfortunate to see their governing body place unnecessary restrictions on their practice.

• Health care unions are concentrating on protecting their interests as opposed to doing what is best for patients and taxpayers.
• Government financed services do not have to be provided by government employees. Union rules just add unnecessary costs to health care delivery.

• The public system is driven by seniority and not performance, which breeds complacency.

• Legislate all health professionals under terms of the Health Professionals Act.

• Public sector monopolies increase the cost of healthcare, maximize the labour required to perform work and reduce the money available for patients and the medical care they need.

• Without any competition from the private sector the unions have extracted unsustainable employment situations.

• Public sector unions are politically motivated organizations. It is questionable whether the priorities of union leaders are focused on patient care.

• Those who are in a position to profit from healthcare are the public sector unions, doctors and others who benefit directly by the elimination of forces of competition.

• **Comments on essential services:**

  • Hospitals are not being run as efficiently as they could be due to notions revolving around time off work. Health care professionals do not see the importance of providing service twenty-four hours a day, three-hundred and sixty-five days a year. Unions are also to blame for perpetuating these types of demands in their contracts. Nurses, for example, wish to be home with their children on weekends during the school year. This is not practical.

  • Non-essential health care union employees are draining the system. Unskilled employees have wages that are too high and they have too many benefits.

**Ideas and Suggestions**

**Collective Bargaining**

**Unions and Professional Associations**

**Essential Services**

• **Ideas about collective bargaining:**

  • Contracts and budgets should provide core services for regions based on present and perceived future demands. It should be reviewed regularly with a small flexibility within these budgets to deal with unforeseen circumstances. The services would then become less politicised and allow for yearly planning.
- We need good Samaritan laws to protect health care providers from lawsuits.
- There needs to be a process for requesting a review when something fundamental has changed.
- We need to write performance-based contracts.
- Do not negotiate contracts with large severance payments if the employee proves to be unsuitable.
- Revamp the collective agreements to have fluidity, to enable health professionals to move between working in a physician’s office one day, in a home care clinic the next, and in an office the next day. The ability to move around to certain locations should exist without losing seniority.
- Bring all medical professions to one table to be involved in the change process, and to facilitate an integrated bargaining approach. Single representation will result in a focused approach.
- We need to retain health professionals by honouring collective agreements and providing the tools and environment they need to do their best work.
- There should be flexibility in collective agreements to address emergency room requirements.
- Contracts for health professionals should include mandatory time spent working in a rural area.
- When hospital employment contracts are signed, salaries and benefit packages should be published. If it was known what those costs were, there would be fewer walk-out threats or strikes, and labour costs would be more reasonable.
- There should be less sick time for health care workers. The first sick day of a stretch of illness should be unpaid. This would stop workers from phoning in sick simply because they want a day off.
- Have a health care negotiation system that removes the threat of withdrawal of services by professional associations and organized labour during contract negotiations.
- Health care, public service contracts should be objectively reviewed. Anti-productive clauses should be modernized to focus on patient care versus union benefits.
- Whatever nurses want they should get, within reason. Other hospital employees should get whatever they want as well. The cleaners have a very difficult job and should be rewarded.
- We need to create career positions rather than casual and part-time positions.
• We need to have more flexible hours especially for employees who have worked over a certain number of years.

• We need a team approach to management where everyone has ownership in the jobs and can see their part of the big picture.

• Allow nurses to speak publicly without consequences, and be able to share what their work-life is really like.

• There needs to be whistle blower protection when someone reports financial abuse in the system.

• All nursing disciplines should be under one collective agreement, like the Nurses Bargaining Association.

• There needs to be more representatives on the bargaining committee, including Northern Health Authority representatives, who are health care providers and not from human resources.

• Maintain social contracts. There is an expectation that the public system will be there when it is needed.

• There should be better relations and more collaboration between labourers and management.

• Honour the collective agreements.

• There needs to be open dialogue between professions, and bargaining units.

• The government should better understand the needs of health care workers and come to the bargaining table in good faith.

• Collective agreements present barriers to team practice. They need to be altered to take collaborative practice and teams into account.

• Ideas about unions and professional associations:

  • The standards and ethical practices of doctors needs to be monitored by an independent body, and not the British Columbia College of Physicians and Surgeons, who are biased and too lenient on doctors who receive serious complaints.

  • We should increase cooperation between the health authorities and the Hospital Employees Union. The liaison between hospital administration and those doing the practical work needs improvement. There is too much wasted labour and funding.
• We need to work on developing a positive relationship between the Ministry of Health and the board of examiners in optometry. There is room for improvement in the development of bylaws and changes in regulations.

• Unions and associations should review their current language, policies and regulations to open up employment opportunities.

• Unions need to be reminded that their work is health care.

• The government needs to stand up to the unions. Unions are controlling the health care system and protecting those who are not doing their job.

• Be firm and resistant to special interest groups and unions.

• Improve health care by eliminating the unions. Overstaffing and sick leave abuse are robbing the health care system of millions of dollars.

• Only fully unionized workers should be employed in health care.

• We have to remind the unionized employees that the system is a public one and not there solely for their benefit.

• We must retrieve our health system from the hands of the government unions. This is the first priority.

• Health care needs to be streamlined. Services that can be provided for less money like the laundry services, or food services should be privatized and non-unionized. These are low-level positions that anyone can perform adequately.

• Shift the power to management and decrease the focus on unions.

• We need to find ways of moving past the union-management adversarial model.

• There needs to be more understanding between management and the unions so that client service remains the most important issue.

• Doctors should be eliminated from professional unions.

• Building a collaborative practice requires meeting with different unions and working through the issues.

• We should stop trying to break the union and, instead, cut wages for upper management.

• The health care system is so massive that it generates its own momentum and its own economy. We have to find a way for the system and the unions to shift their emphasis. Job security and job rigidity need to be separated. Job security is a good thing, but job rigidity is not.

• Unions need to take ownership and contracts need more flexibility.
• There needs to be consistent and fair rules regarding employing nurses from other countries. Unions often complicate this situation.

• A better use of volunteers could save the health care system money.

• Nurses belong to a strong union and this is part of the problem. The government should have more control, and be doing more than just paying wages.

• There needs to be more collaboration among all unions and the government on needed changes in health care.

• We need to work with unions to make the system more flexible.

• When the government provides more health care dollars, it is benefiting the unions. Current contracts should be cancelled and all health care employees should have to reapply and re-qualify for the same positions.

• The current mandate of the Canadian Medical Protective Association needs to be changed.

• The government needs to strengthen its role in dealing with health professionals to ensure interest groups are not responsible for making decisions.

• Legislation needs to be changed to reduce the influence and power of the British Columbia Medical Association.

• Licensed Practical Nurse training should be recognized by the Registered Nurses Association of British Columbia.

• We should attempt to get all health professionals under the Health Professions Act.

• Reduce the lobbying power of associations and unions who restrict practice.

• There needs to be positive relationships between unions and management.

• We need to increase accountability for health care at the provincial level. Each British Columbian should receive an annual statement of health care system usage.

• WorkSafe British Columbia should track claims to find those who abuse the system.

• **Ideas about essential services:**

  • If strikes go on for longer than a week, it should be law that all of the striking workers can be replaced.

  • The focus should be on delivering health care to patients. All non-essential jobs should be privatized.
• Health care is an essential service. It should not be subject to union whims and disruptions. Mediation and meaningful negotiation is important but striking should not be allowed. There should be no right to strike in any government service.

• The right to strike should be eliminated.

• The cost of union contracts has been enormous. Has data been collected to assess the effect?

• What is the purpose of the British Columbia Nurses Union, the Hospital Employees Union and the Health Sciences Association of British Columbia? What are their mandates? They need to be held accountable for their roles in perpetuating problems within the health care system.

• How do doctors manage their patient loads and still make time to stay current on new drugs and treatments?