

AFTERWORD: THE IMPACT OF THE COVID-19 PANDEMIC ON THE CANADIAN HEALTH WORKFORCE

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The COVID-19 pandemic has had a significant impact on the health workforce in Canada. Given that most of the chapters in this text were prepared before March 2020, when the World Health Organization declared COVID-19 a global pandemic, they do not address this issue. This afterword addresses some of the impacts of the pandemic, including specific examples from affected health workers, expanding upon a previously published international overview (Bourgeault et al., 2020).

PROTECTING HEALTH WORKERS

ACCESS TO PERSONAL PROTECTIVE EQUIPMENT

A key issue for health workers during the COVID-19 pandemic has been access to the personal protective equipment (PPE) that can reduce the risk of being exposed to the virus. Information on PPE is part of health workers' right to know about hazardous work environments, as well as their right to refuse unsafe work (Canadian Federation of Nurses Unions [CFNU], 2020a).

Access to PPE has been variable across health worker groups and provinces. A survey by the Canadian Association of Medical Radiation Technologists, for example, found that almost 40% of medical radiation technologists felt they did not have adequate access to PPE and, among that group, 60% said other frontline professionals were being given greater access to PPE (Gold, 2020).

Workers in long-term care, personal support workers (PSWs) and hospital cleaners were not initially considered for distribution of PPE and, as a result, disproportionately exposed to the virus. At one long-term care facility in Ontario, staff reported that only registered nurses had access to N-95 masks during an outbreak, while PSWs and other workers did not (Ireton, 2020).



These situations highlight existing power dynamics within the health workforce in Canada.

There have been multiple calls for transparency in PPE supply and distribution from unions and professional associations across the country. The CFNU, for example, published a statement advocating that the duty to protect health workers and, by extension, their patients lies with the ministries of health and health employers (CFNU, 2020c). The Canadian Union of Public Employees also stressed the fact that PSWs cannot work safely without access to PPE (Fox, 2020).

Efforts to increase access to safe PPE

To increase access for essential workers, the Government of Canada issued a call to action for Canadian manufacturers able to shift production toward PPE or disinfecting supplies, and initiated a federal plan to mobilize the manufacturing industry to produce PPE (Government of Canada, 2020c). The federal plan included refocusing the Strategic Innovation Fund to support the manufacturing

of PPE on large-scale projects, as well as expediting research and development related to COVID-19 through the National Research Council.

The government also passed an interim order to expedite the importation, sale and distribution of PPE and medical devices such as sanitizer, medical gowns, face shields and medical masks (Government of Canada, 2020d). Under the interim order, industry and health professionals can submit an application for COVID-19 medical devices to the federal government (Government of Canada, 2020a). This was intended to support the fair and consistent distribution of PPE, as well as to provide quality assurance and guidelines for use. To help distributors and health workers source more PPE, the federal government launched a database of recently authorized medical devices that is updated daily (Government of Canada, 2020b). The database also includes medical devices for expanded use during COVID-19 and products no longer authorized for use.

COVID-19 INFECTIONS AND DEATHS AMONG HEALTH WORKERS

In many countries, there has been no official record kept on health worker infection and death. Amnesty International (2020) estimated that, as of September 3, 2020 around 7,000 health workers had died of COVID-19 globally.

In Canada, there was little coordination of data collection until late July. According to the Canadian Institute for Health Information (CIHI), health workers account for 19.4% of infections across Canada (CIHI, 2020). Public Health Ontario (PHO) reported that more than 80% of infected health

workers were women and that 13 health workers had died of COVID-19 as a result of occupational exposure (PHO, 2020).

The data on health worker deaths in Canada are inconsistent. While PHO identified 13 health worker deaths in Ontario alone, CIHI reported only 12 nationwide and CFNU collected information on 16 Canadian health worker deaths (PHO, 2020; CFNU, 2020b). Part of this discrepancy may be related to who is (and is not) considered a health worker by those collecting these data. Environmental service workers and administrative support workers, for example, may not be included in some counts of health workers, despite the integral role they play in patient support and the healthcare system as a whole, especially during a pandemic.

In addition to questions of the accuracy of the data, there is also a lack of socio-demographic data that makes it difficult to identify the impact of race on COVID-19 infection and death rates. Anecdotal evidence makes it clear that health workers belonging to racialized groups have been most affected by COVID-19. In a visual memorial page assembled by the Canadian Health Workforce Network (CHWN), eight of the 15 health workers memorialized as of October 2020 were racialized workers, with most of them working in long-term care (CHWN, 2020). This aligns with research indicating that many racialized workers are funneled toward the most precarious parts of the health system, such as long-term care, which often have lower rates of pay, fewer sick days and less job security (Sim, Gupta, & Bourgeault, 2020).

COVID-19 AND IMMIGRANT/REFUGEE HEALTH WORKERS

Data from the Institute for Clinical Evaluative Sciences (ICES) indicates that immigrants and refugees make up a large percentage of the health workers infected with COVID-19. In a study comparing infection rates among newcomers to Ontario with rates among Canadian-born and long-term residents, ICES found that 36% of women who had tested positive were health workers; of those, 45% were immigrants or refugees (Guttman et al., 2020).

These numbers are correlated with the over-representation of immigrants working in long-term care facilities. In metropolitan cities such as Vancouver and Calgary, more than 70% of nurse care aides, orderlies and patient service associates are immigrants (Turcotte & Savage, 2020).

MENTAL HEALTH CONCERNS AMONG DENTISTS

By Jelena Atanackovic

The COVID-19 pandemic and associated social distancing measures have exacerbated the typical stresses faced by dental professionals. Added stressors including being required to close their practices at various stages of restrictions, being redeployed to other areas of the health system to help combat the pandemic and outfitting their clinics with expensive PPE. To address dentists' stress, expanded peer mentorship and support programs that employ proactive approaches to support mental health and well-being are being recommended.

PSYCHOLOGICAL HEALTH AND SAFETY OF HEALTH WORKERS

The safety of health workers extends beyond their physical safety to their psychological health and safety. The CSA Group defines a **psychologically safe work environment** as one “that promotes workers' psychological well-being and actively works to prevent harm to worker psychological health, including in negligent, reckless or intentional ways” (CSA Group, 2018).

Health workers are already subject to many factors that affect their mental health, such as high-stress work environments and concerns about personal safety, and these have been amplified during the pandemic. Heavy workloads, combined with social isolation and distrust due to the volume and contradictory nature of emerging information, create a challenging environment for health workers. Many have reported feeling anxious, overwhelmed, helpless, sleep-deprived and unsafe. Moral distress and burnout have been particularly prevalent, with a recent poll finding that 47% of health workers said they need psychological support (McKinley, 2020).

Mental health resources for health workers

In recognition of the increased need for psychological services among health workers, jurisdictions and organizations have made efforts to increase service availability. For example:

- The British Columbia Ministry of Health produced guidelines for the provision of psychological support for health workers, including strategies for developing a psychological response, providing key interventions for mental health concerns and introducing psychological safety practices through team managers (British Columbia Ministry of Health, 2020).

- The Canadian Psychologists Association implemented a referral program to connect front-line health workers with free counseling services across Canada (Canadian Psychologists Association, 2020).
- The Centre for Addiction and Mental Health's Project ECHO, a virtual support network to connect and assist health workers, was adapted for COVID-19 (Centre for Addiction and Mental Health, 2020).
- The Public Service Health Care Plan was amended to include registered social workers in insurance coverage as mental health practitioners during the pandemic to increase the availability of mental health services (Christianson-Wood, 2020).

Through these and other initiatives, many mental health workers have been mobilized to help provide psychological support during the pandemic. As the demand for these services increases, it is essential that plans to expand access to them during the COVID-19 pandemic maintain the conditions of psychologically safe work environments for all health workers.

EXPANDING SURGE CAPACITY

In a pandemic situation, the normal capacity of a healthcare system may not be adequate to meet needs, so additional surge capacity may be required.

Surge capacity is defined by the U.S. Department of Health and Human Services as “the ability to evaluate and care for a markedly increased volume of patients — one that challenges or exceeds normal operating capacity [which] ... may extend beyond direct patient care to include such tasks as extensive laboratory studies or epidemiological investigations” (Assistant Secretary for Preparedness and Response, 2012).

Several strategies were put in place in various jurisdictions to expand the health workforce capacity by increasing the number of workers available. These included active recruitment, emergency registration and licensure, relaxation of registration and licensure criteria, reinstatement of retirees, and fast-tracking of new graduates. These strategies also help address the loss of health workers from the workforce due to infection and quarantine requirements.

INCREASED CAPACITY THROUGH LICENSING AND REGULATION

Relaxing criteria around registration and licensing is one way authorities created flexibility to rapidly expand health system capacity. All professions established emergency registration and licensure procedures, including a temporary and conditional class of registration that allowed certain workers to enter or re-enter the workforce without fulfilling the usual requirements.

In some jurisdictions, such as Alberta, postgraduate medical trainees who had completed their training and were eligible to take their licensing exams were permitted to apply for independent practice on a provisional register with no practice restrictions (College of Physicians and Surgeons of Alberta, 2020). These types of provisions were also necessary because of the cancellation or postponement of many exams and professional development courses.

Many retired workers reached out to the associations at the beginning of the pandemic to offer support and ask how they can help. These workers had the necessary training and experience to rapidly re-integrate into the workforce and provide care within their scope of practice. In Nova Scotia, for example, physicians who had retired within the last three years could apply for a restricted license and return to work (College of Physicians and Surgeons of Nova Scotia, 2020).

Ultimately, licensure flexibility and changes in regulation have made it possible to increase the numbers of health workers ready to respond to the pandemic. Many of these changes were intended as temporary but have yet to be reversed as the pandemic has progressed and the public health emergency remains in effect.

INCREASED HEALTH WORKFORCE FLEXIBILITY: SCOPE AND LOCATION

The capacity of the health workforce depends not only on the number of workers within the system, but also on the work they do, how they do it and where they do it. In response to the pandemic, health workers experienced changes in both their scopes of practice and the locations where they worked.

Changes in scope of practice

Scope of practice refers to the roles, functions, tasks, activities, professional competencies, standards of practice, entry-to-practice and registration requirements of a particular profession. A number of health workers experienced a change in their scope of practice to better respond to the pandemic.

Government amendments in Alberta gave nurse practitioners the ability to work as primary care providers in nursing homes. This expanded scope involved assessing residents, prescribing medication and delivering follow-up care. The Nurse Practitioner Association of Alberta is working with Alberta Health Services to make this change permanent (Nurse Practitioner Association of Alberta, 2020).

Also in Alberta, speech language pathologists have been provided with additional training and asked to undertake nasopharyngeal swabs for COVID-19 testing, which is outside the typical scope of practice for these professionals (Alberta College of Speech-Language Pathologists and Audiologists, 2020).

Removing or relaxing educational requirements also enabled quick changes in scopes of practice and tasks. For example, the British Columbia College of Nursing Professionals began allowing licensed practical nurses to perform nasopharyngeal swabs for COVID-19 testing without the usual additional educational requirements (British Columbia College of Nursing Professionals, 2020).

Rapid shift to virtual care

Virtual care was not created during the COVID-19 pandemic, but it became one of the most widespread strategies to allow healthcare workers to deliver care while maintaining social distancing. This was especially crucial in the early stages, when guidance on safely

WHAT IS VIRTUAL CARE?

Virtual care is “any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care” (Jamieson et al., 2015). It can be conducted through any technology, including by telephone or video conference, and can be synchronous or asynchronous. Virtual care optimizes both patient and provider safety during the pandemic by limiting exposure and potential for viral transmission (Gadzinski, Gore, Ellimoottil, Odisho, & Watts, 2020).

returning to work was not available. Many workers also relied on virtual care to continue running their businesses and remain financially viable when their offices closed early in the pandemic.

Regulatory flexibility to allow for the inclusion of virtual care within practitioners’ scopes of practice enabled many healthcare workers who had not previously been authorized to provide virtual care or telehealth to work within this new context.

Licensure flexibility around where care was provided also enabled interjurisdictional virtual care. For example, to maintain continuity of care, the Newfoundland and Labrador boards governing psychology and occupational therapy authorized telehealth and virtual services by out-of-province practitioners for clients who had temporarily

relocated to Newfoundland and Labrador due to COVID-19 (Newfoundland and Labrador Psychology Board, 2020; Newfoundland and Labrador Occupational Therapy Board, 2020).

Funding for virtual care — both of the tools that allowed professionals to provide it and of the service itself — was another major facilitator to its uptake by professionals. For physicians, new payment policies and billing codes specific to virtual visits were required to support this shift. On Prince Edward Island, the Health PEI One Island Health System updated its billing codes to account for virtual care for limited office visits, health promotion counselling, psychotherapy, diagnostic and therapeutic interviews, consultations, geriatric follow-up visits, and postnatal visits (Health PEI, 2020a). Billing for virtual care visits must also be recognized by the patient’s insurer; many companies have accepted this, including Sunlife Canada Life, Manulife, Desjardins, Green Shield, Alberta Blue Cross, Pacific Blue Cross and Medavie Blue Cross.

Many provinces, such as Prince Edward Island and British Columbia, also purchased licenses for healthcare workers to support virtual patient care during the COVID-19 pandemic (Health PEI, 2020b; Provincial Health Services Authority, 2020). Some platforms offered free licensing for healthcare workers through their provincial associations in partnership with the provincial governments. One example was *Zoom for Healthcare*, a secure, web-based virtual care video conferencing platform for patients and workers that is compliant with Canadian privacy regulations (Health PEI, 2020b).

CHIROPRACTORS AND TELEHEALTH: A CASE STUDY

Before the pandemic, chiropractors in Canada did not offer telehealth or virtual visits, relying solely on in-person visits and consultations. But for those practising in regions that did not allow for or severely restricted in-person care once the pandemic hit, making the shift to virtual care was essential. By offering telehealth visits, they could help patients with emergent or acute neuromusculoskeletal care needs, potentially enabling them to manage their pain and avoid an in-person visit with a chiropractor or to a hospital emergency room, which would have brought greater risk of COVID-19 exposure (Canadian Chiropractic Association, 2020). To support the shift, the Canadian Chiropractic Association offered chiropractors Virtual Chiro Care, a telehealth software program customized for chiropractic care and compliant with the Ontario *Personal Health Information Protection Act* and the federal *Personal Information Protection and Electronic Documents Act* (PIPEDA).

Staff deployments

Health system capacity can also be adjusted by moving workers around, either within the same organization or to another organization — in some cases, even to another jurisdiction. In either scenario, a worker may retain their scope of practice or expand into new areas.

Moving health workers within an organization is easier because they are already paid by that organization. The lack of funding transferability makes it more complicated to deploy workers to a different organization. Along with the rapid, provisional licensure discussed previously, licensing boards also facilitated the expansion of health system capacity by offering flexibility in permitted scopes of practice, which allowed for deployment within and across organizations. Early in the pandemic, many workers volunteered to be redeployed to other areas with greater need for health workers; however, this is not considered sustainable over the long term.

Staff who are redeployed from one unit of their organization to another may continue providing the same type of care in a different unit or their scope of practice may change. At the McGill University Health Centre, staff were moved to the new COVID-19 unit, a research space converted to increase capacity for COVID-19 patients. Some physicians were redeployed to this unit from less-critical specialties, such as dermatology, and expanded their scope of practice to provide bedside care. Respiratory therapists and nurses were also redeployed to the new unit (McGill University Health Centre, 2020).

Staff who are deployed outside their organizations to places with greater need may also continue providing the same type of care or expand their scope of practice to provide a different type of care. Many Canadian physiotherapists expressed their willingness to redeploy outside their organizations and scope of practice to support the healthcare system during the pandemic. The Canadian Physiotherapy Association has stated that physiotherapists are regulated, trained and able to respond in many areas, including respiratory physiotherapy care, post-traumatic injuries and neurological conditions. Their services in hospitals and long-term care facilities can help enable patients to return home and free up hospital beds (Ris & Dalle-Vedove, 2020).

The expansion of health workers' scopes of practice can be influenced by a number of barriers and facilitators at the system, organizational and practice levels (Nelson et al., 2014). The removal of regulatory barriers and provision of funding for expanded scopes and locations of practice have been key enablers for continuity of care during the pandemic.

CONCLUSION

This afterword highlights some of the ways the pandemic has affected the health workforce in Canada — and how health workers across the country have risen to the occasion to respond in solidarity to meet these challenges. As the pandemic unfolds, the healthcare system will shift from crisis management to thoughtful consideration about how to sustain the health workforce through the pandemic and into the future.

ACRONYMS

CFNU	Canadian Federation of Nurses Unions
CHWN	Canadian Health Workforce Network
CIHI	Canadian Institute for Health Information
ICES	Institute for Clinical Evaluative Services
PHO	Public Health Ontario
PIPEDA	<i>Personal Information Protection and Electronic Documents Act</i>
PPE	Personal protective equipment
PSW	Personal support worker

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