BC WOMEN'S HEALTH FOUNDATION

INVISIBLE NO MORE

Inequities faced by women healthcare workers, especially during the COVID-19 pandemic, + recommendations for actions.

#InvisibleNoMore

THANK YOU

WE RECOGNIZE THE ENTIRETY OF THE HEALTHCARE WORKFORCE, THOSE WORKING IN HOSPITALS, LONG-TERM CARE, LABORATORIES, KITCHENS, AND THE COMMUNITY. WE RECOGNIZE HEALTHCARE WORKERS ACROSS ALL PROFESSIONS: CARE AIDES, HOUSEKEEPERS AND MAINTENANCE STAFF, KITCHEN STAFF, SOCIAL WORKERS, NURSES, MIDWIVES, ANESTHESIA ASSISTANTS, LABORATORY TECHNOLOGISTS AND EQUIPMENT TECHNICIANS, AND MORE.

We recognize the stresses of frontline positions, the understaffing, the physical work, and risk of violence. We recognize the immense pressure that COVID-19 has added with a lack of protective equipment, continuously changing protocols, increased workloads, limited time and training, and the added layers of fear around taking the virus home, in addition to grief, these circumstances bring.

We recognize the gap in compensation experienced by many healthcare workers across genders, professions and locations, with many lacking access to sick leave and basic benefits. Many have been working multiple jobs to make a living wage. We also recognize the perpetual undervaluing of care work in our society.

We recognize the depth of compassion healthcare workers have for their patients and co-workers. The countless hours dedicated to ensuring the highest quality of care, whether paid or unpaid, which most times goes unnoticed.

We recognize the second shift that many healthcare workers managing, providing countless hours of unpaid care to disabled or elderly family members, and the added challenges parents have managing childcare before and during the pandemic.

We know as a society we now need to go beyond sentimental gestures to practical action. We are committed to advocating for change. And we are committed to working alongside key stakeholders to ensure that healthcare workers have what they need to thrive in the essential roles they play in society.

Thank you,

BC WOMEN'S HEALTH FOUNDATION

HOSPITAL EMPLOYEES' UNION CUPE

HSA

INTRODUCTION

In March 2020, every night around the globe, we started banging pots and pans for healthcare workers to recognize the colossal efforts they have made to support those infected by COVID-19, protect populations of high vulnerability, and continue to deliver the essential healthcare services society relies upon.

Today, those sentimental gestures are long since over. However, the underlying burden of this ongoing crisis remains. The seismic impact on the workers who comprise the healthcare sector and its viability, are in great peril.

Over 80% of the healthcare workforce in BC are women[1]. The health and social care roles women fulfill are distinctly gendered, not because women are physiologically predisposed to care work but rather because of norms and expectations around who does what within families, the health system and society.

Over the past year, BC Women's Health Foundation (BCWHF) initiated two research projects to understand the experiences of women healthcare workers during the pandemic. Leading researchers, Dr. Julia Smith and Dr. Rosemary Morgan, explored current evidence and conducted virtual focus groups and interviews with healthcare workers from a breadth of professions and representatives from the sector, unions, and professional organizations. Dr. Joanie Sims-Gould and Dr. Thea Franke more closely explored experiences within the long-term care sector.

Combined, the outcomes of this research forms the *Invisible No More* report, the next in BC Women's Health Foundation's *Unmasking Gender Inequity* series. This report peels back the compounding layers of invisible barriers and inequities impacting healthcare workers before and during the COVID-19 pandemic. It provides recommendations for action and outlines clear roles for key stakeholders in building a more equitable and sustainable healthcare workforce.

INVISIBLE NO MORE

FORGOTTEN PROFESSIONS

The BC Government defines healthcare workers as 'persons who provide healthcare to patients or work in institutions that provide patient care[2]. Nurses and physicians are essential. So too are the often-forgotten professions. For example, anesthesia assistants, laboratory technologists and equipment technicians, dietitians, hospital pharmacists, radiation therapists, housekeeping staff, care aides, food and custodial staff, and community care workers provide support to countless vulnerable patients* and families in communities province-wide. This report highlights the layers of complexity and challenge healthcare workers experience daily.

"I FELT THAT WE WERE, AS FRONTLINE WORKERS, SUPPORTING OUR CLIENTS THROUGH THE PANDEMIC AND ALL THEIR ANXIETY AND NEEDS…BUT WHAT I ACTUALLY FELT DEEP DOWN INSIDE WAS MY OWN ANXIETY. I WAS WORRIED ABOUT CATCHING COVID AT WORK AND BRINGING IT HOME TO MY FAMILY."

- Community care aide

HIGH RISK AND HIGH STRESS

Prior to the pandemic, healthcare workers reported understaffing, inadequate training, insecure working arrangements, and working multiple jobs to make ends meet. Wider evidence confirms regular accounts of verbal and physical abuse[3,4]. The onset of the pandemic increased these stresses through increased risk of exposure, increased workload, and layers of grief, guilt, and isolation.

INCREASED RISK OF EXPOSURE

Women discussed the added stress related to the risk of contracting COVID-19. As shown in BC Women's Health Foundation's *Unmasking Gender Inequity* report, healthcare workers continually ranged highest in risk of infection. Data from the BC Centre for Disease Control[5] shows this risk actualized, with nurses having the highest infection rates among healthcare workers, followed closely by care aides. Many women felt that their risk of exposure went unrecognized, particularly those in community health settings. Healthcare workers also suffered relentless, underlying anxiety around contracting COVID-19 at work and spreading it to family members and others.

*The term 'patients' is used within this report to refer to all persons receiving healthcare by across all private, public and community locations.

"SO, WE RECENTLY HAD AN OUTBREAK HERE…WE CAME IN TO WORK NOT KNOWING WHAT WE WERE WALKING INTO. AND THERE WAS CHAOS. CHAOS WAS EVERYWHERE. WE WERE LOSING RESIDENTS THAT YOU BECOME VERY CLOSE WITH. EVEN THOUGH I'M A HOUSECLEANER, WE WERE REALLY HIT HARD. YOU BECOME PART OF THEIR FAMILY. EVEN WHEN THEY DO PASS – BEFORE COVID-19 HIT, YOU WERE GOING TO THESE RESIDENTS' FUNERALS. BECAUSE YOU'RE PART OF THEM."

- Housekeeper

LIMITED ACCESS TO PERSONAL PROTECTIVE EQUIPMENT (PPE)

Women observed that access to PPE helped mitigate risk and conveyed a sense of protection. However, healthcare workers had varying experiences accessing PPE. Some had ready access; others had to source, or even make, their own. Midwives recalled requesting donations from community members and clients. Others had to seek approval whenever they needed to restock or reuse gloves and masks due to rationing. Others were denied gloves and just told to wash their hands. They felt undervalued by leadership when comparing access to PPE between healthcare providers.

INCREASED WORKLOAD AND COMPLEXITY

Healthcare workers experienced sudden and drastic increases in already heavy workloads during the pandemic. Nurses and midwives described how the medical issues they were treating changed, challenging their expertise and skillsets and intensifying stress. Those working with priority populations, such as patients who use substances or are experiencing homelessness, faced higher caseloads due to disproportionate pressures affecting their patient populations. Midwives experienced higher demand as home births kept pregnant mothers out of hospital.

Community health and care workers noted increased emotional and socialization needs of patients due to isolation and lack of supports. While many participants expressed pride in stepping up to new challenges and learning new skills, unmanageable workloads limited those empowering experiences.

INCREASED GUILT AND GRIEF

Many healthcare workers expressed guilt regarding the necessary time spent donning PPE in emergencies, which impacted patient care and outcomes. Nurses described that their instinct was to rush into patient rooms requiring urgent care but they had to take the time to put on their PPE first to protect themselves. Doing so resulted in self-blame for what some perceived as *"wasting time,"* as well as profound grief when these situations ended with patient deaths.

"YOU NEED TO UNDERSTAND THAT WE BIRTH. WE GET COVERED IN FLUID. WE GET SPAT ON. WE GET VOMITED ON. WE HAVE AMNIOTIC FLUID ON US, POOP, EVERYTHING. WE ARE OUT IN THE COMMUNITY. YOU MAYBE DON'T KNOW WE'RE HERE, BUT THIS IS WHAT WE'RE DOING. WE NEED PPE."

- Midwife

"As hard as it was for the hospital, **THESE CHANGES WERE HORRIFIC** for [home and community care]. They have way less staff, they have way less leaders, and we were shovelling people out the door of the hospital into homecare by the bucketload, and it's not like they've got a huge pool of people to call into work. So as hard as it was in the hospital, and as much attention everyone driving by the hospital honking and thanking them, [the wider] community was dying. **IT WAS TERRIBLE.**"

- Community healthcare worker

Healthcare workers described going through trauma, stress, and grief while supporting and caring for patients during the pandemic. Those working with patients vulnerable to COVID-19 infection expressed feelings of hopelessness and heartbreak, wondering if their patients would make it through the pandemic. High workloads made it difficult to find the time to decompress from challenging and traumatic situations.

"SOMETIMES YOU GO THROUGH SECOND-HAND GRIEF ALMOST, GOING THROUGH A DIFFICULT SITUATION AT WORK, AND YOU FEEL REALLY OVERWHELMED. BUT THE DEPARTMENT IS BUSY, SO YOU CAN'T GO FOR A WALK…YOU CAN'T REALLY DECOMPRESS."

- Nurse

COMPENSATION DISPARITIES

The extent of compensation disparities for healthcare workers is substantial, with gaps between professions, genders, and healthcare settings. These are all underlined by a devaluing of care work. Care work remains low-wage work, with a mean annual employment income for women care workers 18% below the mean for women workers in Canada[6]. Care work is feminized. As such, the norms, values, pay, and working conditions suffer due to social assumptions that women's "natural" abilities, family roles, and subordinated place in society make them ideal for this work. It often includes work that is usually considered unskilled or low skilled[7].

While men make up a small proportion of the healthcare workforces, they make an average of 16% more than women each year[8]. Evidence points to a gendered 'care vs cure standard,' where male-dominated professionals, such as physicians, are expected to 'cure' and thus deserve high pay and prestige. In contrast, female-dominated healthcare professions, such as nurses and community health workers, are expected to provide services more aligned with women's traditional gender roles and thus require less skill and are motivated by altruism instead of salary[9].

Beyond these gaps, healthcare aides have huge disparities in wages between locations. In long-term care, workers reported earning such low wages that they had to work up to seven days a week in multiple locations. COVID-19 protocols restricted workers from working in more than one healthcare site, resulting in further financial challenges. Recent analysis shows that long-term care workers make $1,684 less a year than comparable workers in other healthcare settings[10]. Yet this is a reverse of the complexity of care required by residents in their old age.

"WE'RE GETTING THESE EMAILS THAT ARE TALKING ABOUT 'PHYSICIAN AND NURSE COMPENSATION FOR YOUR HEROIC EFFORTS'... MEANWHILE, EVERYONE'S STRUGGLING... ... [IT IS] THIS COMPLETE INVISIBILITY OF THE WORK THAT WE DO AND THE FACT THAT NOBODY EVEN THINKS ABOUT HOW HARMFUL THAT WOULD BE TO RECEIVE AN EMAIL THAT DISCRIMINATES AGAINST YOUR [PROFESSION]."

- Midwife

PANDEMIC PAY FOR SOME AND NOT OTHERS

While the BC, government has made strides to address wage inequities by implementing wage levelling early on in the pandemic so that all workers in long-term-care and assisted living made the same wage as those covered by public sector collective agreements in those sectors, this didn't dismantle all inequities in pay.

In addition, disparities in the distribution of pandemic pay - an increase in the hourly salary of specific frontline workers for 16 weeks starting in March 2021 - left many healthcare workers feeling frustrated and discouraged. For example, the designation of midwives as allied staff meant that they did not receive temporary pandemic pay. Several midwives also described how physicians received substantial funding from the government to implement COVID-related safety measures and virtual care in their clinics. In contrast, midwives did not receive this economic support, causing financial insecurity among those who had to utilize personal savings to adapt their services accordingly.

LIMITED BENEFITS

Healthcare workers raised concerns around the financial implications of taking time off during the pandemic, either for childcare purposes or due to COVID-19 infection. Multiple women spoke of having no, or inadequate, paid sick leave. COVID-19 was listed by WorkSafe BC as an occupational risk illness for certain nursing professions, enabling quick access to coverage after exposure.

"OH, YOU'RE SICK? YOU'RE STILL COMING TO WORK," THAT'S WHAT WE GET. BUT, YEAH, WE GO TO WORK SICK. THEY'RE ACTUALLY FIRING PEOPLE THAT AREN'T COMING TO WORK BECAUSE THEY'RE SICK. IF THEY'RE ON PROBATION, IF THEY'RE JUST HIRED, IF THEY MISS THREE DAYS, THEY'RE GONE. AND THIS IS WHAT'S HAPPENING. BUT THAT'S OK, BECAUSE WE'RE JUST HOUSEKEEPERS. THIS IS HOW WE'RE TREATED."

- Custodial worker, long-term care

However, others were required to put in substantial effort to prove they had contracted COVID-19 at work before being permitted to access benefits. Some healthcare workers were actively encouraged to come in to work despite illness.

"[IN THE] ELEVATORS TO THE PERINATAL UNIT WAS THIS SUPERMAN FIGURE... STARTING TO RIP OPEN HIS SHIRT WITH HAIRY MAN HANDS... I REALLY DID NOT IDENTIFY WITH THAT... I DON'T FEEL LIKE ANYONE KNOWS I'M HERE AND WHAT I DO HERE... NOBODY WANTS TO BE A HERO. NOBODY WANTS TO BE WORKING IN A PANDEMIC. AND THAT'S NOT THE ACKNOWLEDGEMENT THAT I WANT. I JUST WANT THE BASIC STUFF."

- Midwife

BURDEN OF CARE

Care work is compassionate work. But with the added stresses of the pandemic, women healthcare workers feel like they are sacrificing themselves for the benefit of others. Even when they desperately needed time off, healthcare workers described feeling responsible for the enhanced strain that taking time off would put on team members. Some described undergoing traumatic situations at work where they needed time at home to decompress but felt too guilty to do so. Those in long-term care felt obliged to work long hours and take on extra tasks, recognizing residents' basic rights to care and increased needs due to the lack of family support. Midwives felt guilt when COVID-19 related restrictions limited their ability to provide the same level of care as before the pandemic, leading them to compromise their own well-being to provide essential services. Many women shared feelings of having their compassion exploited.

Messaging around healthcare workers being "heroes" during the pandemic did not resonate with many healthcare workers. Many thought it demonstrated the "martyr complex" that health systems capitalize on, wherein women are made to feel that their passion for serving their patients is worth the sacrifice of lower pay and poor working conditions. Previous pandemics have also noted leveraging women's duty-to-care to pressure them into accepting unsafe working conditions[11].

"THE TERM [IS] COMPASSION EXPLOITATION… LOOK HOW MANY WOMEN WORK IN HEALTHCARE…SOCIETY HAS FOSTERED THAT WOMEN ARE COMPASSIONATE. THEY HAVE CREATED THIS, AND I DO THINK THAT THAT IS DEFINITELY BEING EXPLOITED DURING THE PANDEMIC."

- Community care worker

RACISM AND IMMIGRATION

A disproportionate number of healthcare workers are new immigrants and women of colour. Of Canada's nurse aides, orderlies and patient service associate positions, 31% are held by immigrant women, which increases significantly in urban areas[12]. In long-term care, healthcare workers are disproportionally Black and Filipino women[13]. These positions have the lowest pay and benefits. In the long-term care sector, deregulation of work arrangements drives down wages and increase levels of exploitation and vulnerability[14]. Unsafe and poor working conditions of feminized and racialized healthcare positions, particularly in the long-term care industry, have been termed 3D: dirty, difficult, and increasingly dangerous[15].

"WE ARE CARING PEOPLE, AND WE CARE. WE GO ABOVE AND BEYOND BECAUSE THAT'S WHAT DRIVES US, AND WE'RE PASSIONATE…IT DOESN'T FEEL GOOD TO LEAVE PEOPLE WITHOUT HAVING A BATH FOR FOUR WEEKS. IT DOESN'T FEEL GOOD TO NOT PUT THAT LIPSTICK ON THAT ONE LADY WHO IT JUST BRIGHTENS UP HER WHOLE DAY."

- Long-term care worker

This care work is not only racialized by the disproportionate number of women of colour working in these roles but by social norms that suggest that it is 'normal' or 'culturally appropriate' for them to do so[16].

Beyond structural racism, healthcare workers experience interpersonal forms of racism from work colleagues, residents, and families. These incidents are often minimized as differences in 'culture' and underreported[17]. Violence is a real problem in long-term care facilities, with reports of 43% of workers experiencing it daily and 23% on a weekly basis[18] prior to the pandemic.

With the addition of COVID-19, racialized healthcare workers reported heightened levels of racism from clients and co-workers. Long-term care workers of Asian descent reported being told to "go back to China" and having residents refuse their care. Black, Indigenous and Women of Colour (BIWOC) spoke of being made to feel like they were more likely to bring COVID-19 into facilities, and others reported being told not to speak their first language during breaks, which limited their access to peer support to deal with stress and anxiety. Focus group participants also noted that information was only provided in English in most long-term care facilities, despite English not being the first language for over 60% of those working in long-term care[19].

THE 'SECOND SHIFT'

Women not only hold most healthcare roles, but they also hold the majority of care responsibilities within families and communities. Before the pandemic, women in BC already worked an estimated six million collective unpaid caregiving hours a week to support people who have long-term illnesses, disabilities, or are aging[20]. This is often on top of childcare responsibilities.

Many healthcare workers had difficulty balancing growing responsibilities associated with the pandemic both at work and at home. One healthcare worker spoke of returning home to a 'second shift' of caring for an elderly mother and sister with health concerns, both of whom she was terrified of infecting with COVID-19.

"I WANT THAT JUST SO LOUD AND CLEAR…MOMS AREN'T HEARD. I FEEL LIKE THAT'S WHAT'S GOING ON. WE'RE THE CARE AIDES, WE'RE THE MOMS, WE'RE NOT BEING HEARD."

- Community care worker

"The biggest thing at the very beginning for myself was my childcare for my dependents …I basically had to take 50% of my job off to care for them because, at least in our community, **THERE IS AN ABSOLUTE CHILDCARE CRISIS ALREADY.** And COVID made that so much worse."

- Community healthcare worker

"I WOULD LIKE TO AT LEAST BE INVOLVED. IF THEY'RE GOING TO IMPLEMENT A NEW CHANGE OR POLICY, I WOULD LOVE FOR MY OPINION TO BE HEARD, OR MY THOUGHTS, JUST BECAUSE I THINK THAT A LOT OF THE INITIATIVES TAKEN SOMETIMES AREN'T TAKEN FROM THE FRONTLINE STAFF'S CONSIDERATIONS – LIKE, HOW MUCH TIME THAT ADDS TO OUR DAY. OR HOW MUCH THAT SMALL CHANGE AFFECTS PATIENT CARE OR TIME MANAGEMENT."

- Nurse

Schools and childcare facilities were closed between March and June 2020, with many subsequent interruptions due to COVID-19 exposures. Healthcare workers described the stress of problem-solving around childcare and weighing the risks of alternatives, such as having an older or immunocompromised family member watch their children. This was especially difficult for single parents or those whose partners were also frontline workers. Many mothers were unable to access childcare for essential workers due to lack of availability, clarity regarding who qualified, and the flexibility required to coordinate logistical issues. Most also felt unable to draw on family or social networks, recognizing their work put them and those in their bubbles at high risk. The stressors of dual care meant many women had to take unpaid leave resulting in absenteeism from work.

Participants' stress and anxiety around their family's well-being made it difficult to focus on their work. On the other hand, increased time spent at work on growing patient caseloads and infection control protocols restricted participants' time with their families, causing guilt and stress. Participants also felt overwhelmed by their inability to take breaks, even when they had days off, because of their dual role as health providers and mothers.

EXCLUDED FROM DECISION-MAKING

While women make up 80% of the healthcare workforce, they reach disproportionately fewer leadership positions in hospitals and other healthcare organizations. This is reflected at all scales of the healthcare profession and is related to a series of barriers that hold women back[21]. During the pandemic, only 22% of participants in our research had input into COVID-19 related decision-making within the healthcare system. This had a demonstrable impact.

IMPRACTICAL AND CONSTANTLY CHANGING PROTOCOLS

Healthcare workers voiced frustration that regulations established by leadership were not always practical at the direct care level, particularly in high-stress situations when patients and clients needed urgent care. It was stressful for workers to learn and adapt to constantly changing unfamiliar regulations. Lack of involvement in policy development made it challenging to communicate their needs.

"IT'S BEEN OVER A YEAR, AND IT'S JUST LIKE, 'I'M OK. I'M OK. EVERYTHING'S FINE.' AND THEN TWO WEEKS AGO, IT WASN'T FINE. I WAS NOT IN A GOOD PLACE. I JUST WANTED TO STAY IN BED AND FORGET ABOUT THE WHOLE WORLD OUT THERE."

- Custodial and food service worker

DECISIONS FROM A DISTANCE

Many long-term care workers recounted a common experience of employers or managers working from home, directing protocols with little insight into the day-to-day running of facilities. Said one, "The door was closed, the lights were off and [our manager] just never showed up."

Many healthcare workers noted a gendered and racial dynamic where those in privileged positions were making decisions regarding the safety procedures for BIWOC women that were doing the high-risk work.

LONG-TERM IMPACTS OF THESE LAYERS OF INVISIBILITY

The collective stories shared by healthcare workers disclosed the consequences of inequity on their health, patient care, and the overall sustainability of the healthcare system

HEALTHCARE WORKERS

Healthcare workers physical and mental health

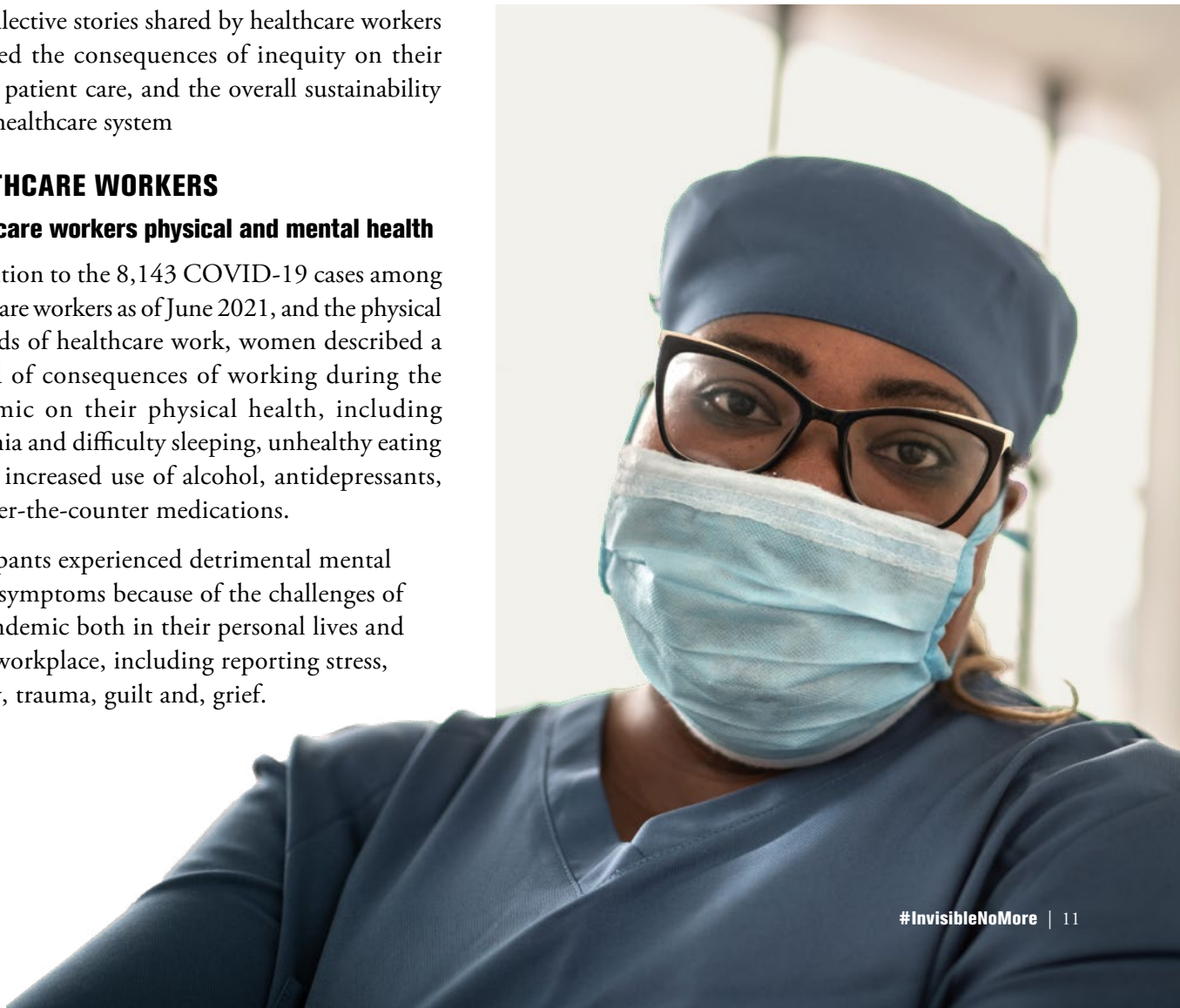
In addition to the 8,143 COVID-19 cases among healthcare workers as of June 2021, and the physical demands of healthcare work, women described a myriad of consequences of working during the pandemic on their physical health, including insomnia and difficulty sleeping, unhealthy eating habits, increased use of alcohol, antidepressants, and over-the-counter medications.

Participants experienced detrimental mental health symptoms because of the challenges of the pandemic both in their personal lives and at the workplace, including reporting stress, anxiety, trauma, guilt and, grief.

The compounding layers of stressors detailed within this report overwhelmed healthcare workers' ability to cope. Several participants either began therapy or increased their number of counselling sessions during the pandemic.

"I WAS DIAGNOSED WITH SEVERE DEPRESSION, SEVERE ANXIETY IN THE CONTEXT OF POST-TRAUMATIC STRESS DISORDER. I HAVE NEVER HAD MENTAL HEALTH ISSUES IN MY ENTIRE LIFE. I CAN ACTUALLY TALK ABOUT THAT TODAY WITHOUT CRYING, BUT SEVEN MONTHS AGO IF YOU ASKED ME HOW WAS WORK, I'D BURST INTO TEARS AND SHUT DOWN."

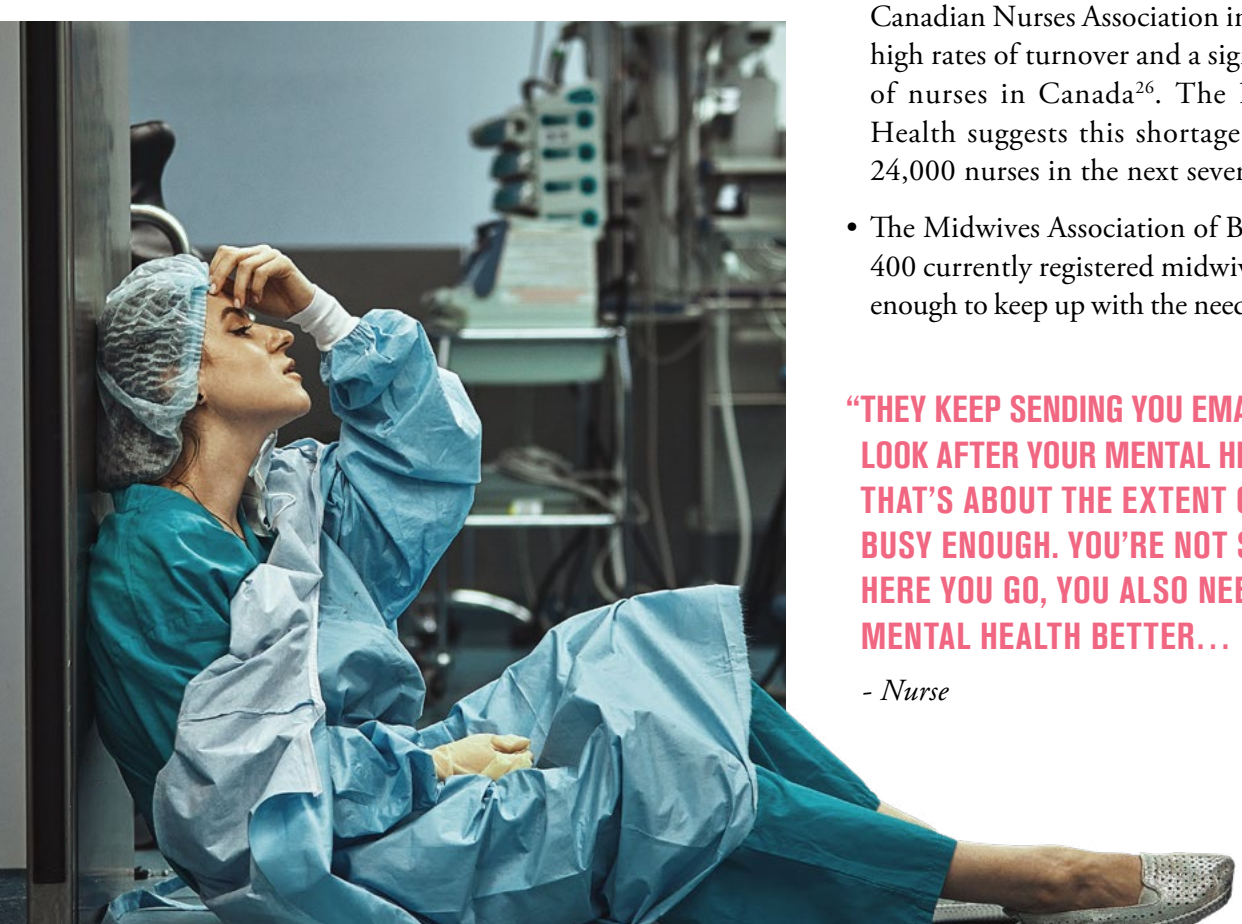
- Nurse



BURNOUT

Many participants confronted being burnt out, especially during the pandemic. Existing research on burnout in the midwifery community showed 45% of midwives reported moderate to high occupational burnout in 2017, which reached 77% with the pandemic[22].

Yet many healthcare workers commented that burnout was part of the staffing strategy. A long-term care facility manager noted that her employer had "the leanest staffing model to save money," but it was so lean you "couldn't survive one sick call." She noted that when there was an outbreak, many staff refused to come in or called in sick, which increased pressure on existing staff, which in turn increased their risk of burnout, contributing to what she describes as a "vicious cycle."In responding to these challenges, women drew strength from their co-workers, unions, and families. Many were aware of over-the-phone counselling programs available through their employer or union, but kind words and virtual services did not meet the most pressing needs of healthcare workers.



Healthcare workers suggested that employers provide more personal mental health resources that actively engage them in the workplace. Having a professional mental health counsellor on-site was suggested as an active way to support mental health.

HEALTHCARE SYSTEM

There are not enough healthcare workers to keep up with current or future demand

BC's population is projected to grow by 1.4 million over the next two decades, with a 63% growth in the proportion of people over 65[23]. With so many healthcare workers leaving the profession because of the pandemic, there is evidence and concern there will not be enough to serve the population in the future.

- The number of vacancies in the healthcare and social assistance sector reached an all-time high of 100,300 positions at the end of 2020[24].
- With an aging population, the long-term care sector needs to recruit an additional 15,400 healthcare workers to meet the need of 40,300 by 2035[25].
- Long before the pandemic, a report by the Canadian Nurses Association in 2009 identified high rates of turnover and a significant shortage of nurses in Canada[26]. The BC Minister of Health suggests this shortage could be up to 24,000 nurses in the next seven years[27].
- The Midwives Association of BC states that the 400 currently registered midwives in BC are not enough to keep up with the need for midwifery[28].

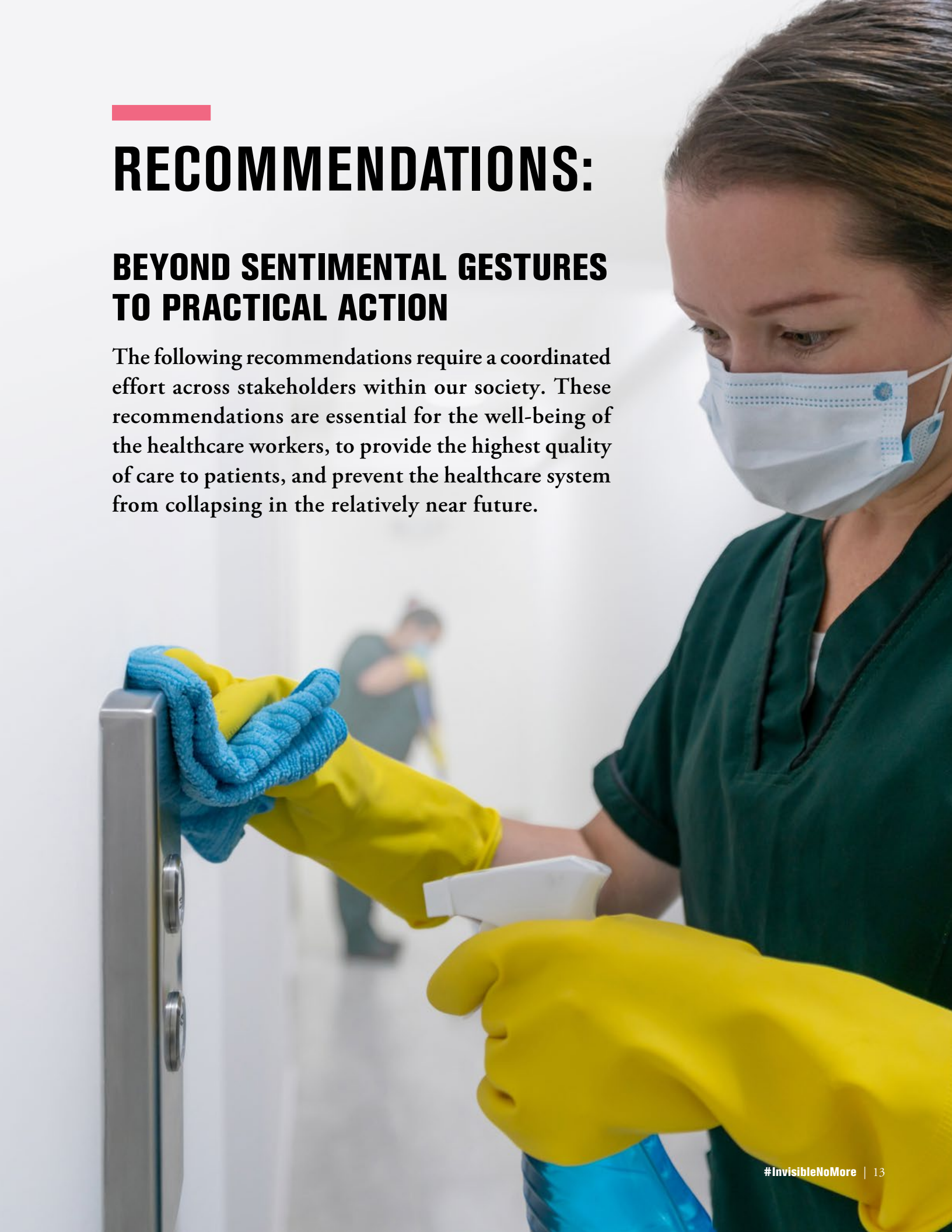
"THEY KEEP SENDING YOU EMAILS AND 'BY THE WAY, LOOK AFTER YOUR MENTAL HEALTH, HERE'S A LINK.' THAT'S ABOUT THE EXTENT OF IT… 'YOU'RE NOT BUSY ENOUGH. YOU'RE NOT STRESSED ENOUGH. HERE YOU GO, YOU ALSO NEED TO MANAGE YOUR MENTAL HEALTH BETTER… IT'S ON YOU.'"

- Nurse

RECOMMENDATIONS:

BEYOND SENTIMENTAL GESTURES TO PRACTICAL ACTION

The following recommendations require a coordinated effort across stakeholders within our society. These recommendations are essential for the well-being of the healthcare workers, to provide the highest quality of care to patients, and prevent the healthcare system from collapsing in the relatively near future.



01

RECOGNIZE FORGOTTEN PROFESSIONS

Raise awareness of the range of healthcare worker roles with the public. Advocate efforts to drive more equitable compensation for forgotten professions. Raise awareness of the gendered view of care, complexity, and contribution of care roles in society, and the current unpaid/under-paid contributions of care workers, to directly challenge current perceptions and the exploitation of unpaid care work. Prioritize the resumption of negotiations around the 2019 Midwife Master Agreement, recognizing midwives as essential workers that should receive the same support as other healthcare professions.

02

CREATE SUSTAINABILITY IN THE HEALTH SYSTEM TO REDUCE PRESSURES ON HEALTHCARE WORKERS

Invest in training and recruitment of health and social care workers, including incentives to ensure that there is enough to meet current and future demand, helping to alleviate unsustainable workloads and burnout.

03

ENSURE COMPENSATION IS EQUITABLE AND REFLECTS THE IMPORTANCE OF CARE ROLES

Provide fair remuneration and better employment protections, including paid sick leave and benefits. Ensure COVID-19 is designated as a WorkSafe BC occupational risk illness for all health and social care occupations to facilitate coverage for sick pay and disability benefits. Implement pay equity and transparency measures that complement and strengthen the federal Pay Equity Act. Ensure these evaluate gender, race, and ethnicity to uncover and address compensation inequities.

04

FACILITATE SUPPORT AND ACTION FOR ACTS OF RACISM, DISCRIMINATION, AND HARASSMENT

Ensure employees have access to confidential, third-party support to report and seek recourse in the event of racism, discrimination, or harassment. Provide ongoing and mandatory diversity, equity, and inclusion training for managers and employees.

05

INVEST IN THE INFRASTRUCTURE THAT REDUCES THE BURDEN OF 'SECOND SHIFT' CARE

Invest in onsite childcare at health facilities to meet the need of healthcare workers. Accelerate commitments to affordable and accessible childcare in BC. Additionally invest in keeping up with the long-term care demand and training of healthcare workers to reduce the potential for shortages in long-term care that will fall to women as unpaid 'second shifts'.

06

INCREASE WOMEN'S REPRESENTATION IN DECISION MAKING

Ensure that Indigenous women and Two-Spirit people, and racialized women are included in decision-making and health leadership positions. To achieve this, establish clear targets for women's representation at decision-making tables in the healthcare sector in BC that are published and tracked publicly. Additionally, invest in leadership training for women to support their contribution at leadership and decision-making tables.

07

PROVIDE PROVEN, PROACTIVE, ONSITE SUPPORTS FOR THE HEALTH AND WELL-BEING OF HEALTHCARE WORKERS

Offer proactive support for mental health and burnout, such as burnout prevention initiatives and having mental health professionals available for debriefing and counseling on an ongoing basis in addition to onsite support during crises.

"WE HAVE PERSONAL DAYS WE CAN TAKE. I'VE TRIED TO TAKE SIX AND BEEN DENIED BECAUSE WE DON'T HAVE STAFF COVERAGE… PEOPLE ARE BURNT OUT, BUT I'M NOT TIRED OF NURSING. I LOVE NURSING; I JUST THINK I'M OVERWORKED."

- Nurse

BCWHF COMMITMENTS

EDUCATION + AWARENESS

We are committed to raising awareness of the experiences of healthcare workers in BC through public campaigns. This will ensure that all stakeholders have the information to take informed action and help society appreciate the breadth and depth of professions, complexity of healthcare work, and the issues healthcare workers face.

ADVOCACY

Work with unions and other stakeholders to support their advocacy efforts for fair remuneration, transparent pay, paid sick leave and benefits for all healthcare workers, in addition to proven health and well-being supports. Advocate to, and work with, federal and provincial governments to track data on healthcare workers, to include metrics on race and gender, and contribution at decision making tables.

RESEARCH

Continue to invest in research that uncovers the gaps in our society that impact women's health. Actively support in the knowledge translation and public awareness campaigns for research focused on the health, wellbeing, and experiences of women healthcare workers.

ACKNOWLEDGEMENTS

BC WOMEN'S HEALTH FOUNDATION EXTENDS ITS PROFOUND GRATITUDE TO EVERYONE WORKING IN HEALTHCARE. WE WOULD ESPECIALLY LIKE TO THANK EVERYONE WHO CONTRIBUTED TO THIS REPORT.

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- And to the **donors of the BC Women's Health Foundation** – your generosity and commitment inspires us and drives work we do.

METHODS

THIS REPORT INCLUDES RESEARCH FROM SEVERAL SOURCES.

Research conducted by Dr. Julia Smith and Dr. Rosemary Morgan as part of the COVID-19 and Gender Project based out of the Faculty of Health Sciences at Simon Fraser University, was the foundation for this report. Their research involved sixteen virtual focus groups with a total of 66 participants identifying as a woman, aged 19 or older, and currently working in the BC health or social care system (between December 2020 and March 2021). Twelve individual semi-structured interviews with healthcare workers and key informant interviews with representatives from sector, unions and professional organizations, supplemented the focus groups. Participants received honorariums, and psychological support was available during calls if needed. Participants came from the following categories of healthcare workers: custodial and food services, community and social care, long-term care workers, midwives, and nurses. All quotes within this report are from this research.

The above research was complimented by research conducted by Dr. Joanie Sims-Gould and Dr. Thea Franke. This involved extensive scoping reviews to analyse existing reports on the long-term care sector and analysis of recent interviews with nurses and care aides within the sector to create vignettes of healthcare workers. Supplementary evidence was collected in interviews of 10-12 researchers, policy, and decision makers in the long-term care sector focused on key issues and recommendations for the sector.

Data was also pulled from the BCWHF *Unmasking Gender Inequity* report, contributed to by Dr. Marina Adshade. Dr. Adshade's analysis of the Vancouver School of Economics' VSE COVID-19 Risk/Reward Assessment Tool by gender and income is explained here and the interactive data can be explored here.

INVISIBLE NO MORE

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We acknowledge with gratitude that we carry out our work on the traditional, ancestral, and unceded territories of the sḵwx̱ wú7mesh (Squamish), seil̓ íl̓ witulh (Tsleil-Waututh), and xʷməθkʷəy̓ əm (Musqueam) nations.

When we refer to "women", we are referring to women in all their diversity, inclusive of LGBTQ2IA+ individuals.