

**Perception of Professionalism and Impacts on
Health Human Resource Decision-Making**

By

Julia Bilinski

B.A. University of British Columbia, 2018

A Thesis Submitted in Partial Fulfilment of the
Requirements for the Degree of

MASTER OF PUBLIC ADMINISTRATION

in the School of Public Administration

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University of Victoria

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Supervisory Committee

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Julia Bilinski

B.A., University of British Columbia, 2018

Supervisor:

Robert G.W. Lapper, K.C.

School of Public Administration, University of Victoria

Member:

Dr. Jason Hicks

School of Public Administration, University of Victoria

Abstract

Health human resources have been strained due to global health emergencies and previous decisions that shape care policies and delivery today. This thesis explores the perception of professional legitimacy of healthcare occupations by health human resources decision-makers, by bringing two British Columbia case studies and perspectives of decision-makers into the academic discourse. The focus of the analysis is the possible effect of the occupational regulatory status of healthcare workers on the perception of professional legitimacy among decision-makers and the potential effect of this perception on Health Human Resource policy. The analysis of two case studies, Bills 29 and 94: Impact on Unregulated Healthcare Workers, and Changes to the *Health Professions Act*, and interviews with former provincial decision-makers in health human resources, yielded many themes that align with the reviewed literature. This thesis finds that regulatory status might affect the perceived professionalism of healthcare occupations by making decision-makers more likely to listen to a regulated occupation. Recommendations are also presented that include increase of inclusive government consultation and collaboration, use of Gender-based Analysis Plus, integration of a public interest perspective, and bias training for public servants to promote greater representational equity of all health occupations in policy decisions in human health resources.

Key Words: occupational regulation; health human resource policy; health occupations; health sector workforce; decision-makers; professional legitimacy

Executive Summary

This thesis explores the potential relationship of perception of professional legitimacy of healthcare occupations by health human resource (HHR) decision-makers. HHR staffing is strained globally, and professional legitimacy is a topic of concern relating to occupational regulation. Many healthcare professions in Canada are self-regulated and derive benefits from occupational regulation. Including an increase in perception of professional legitimacy by others, expansion and control of scope of practice, and reduction of competition from other occupations. However, this privilege may perpetuate the hierarchy of healthcare occupations at the detriment of unregulated occupations, and negatively influence HHR policy and decision-makers. Unregulated healthcare occupations usually garner less attention and are understudied in academic research.

The goal of this study is to explore three research questions:

- 1) Does occupational regulatory status of healthcare workers impact their perceived legitimacy by decision-makers in British Columbia HHR policy decision-making?
- 2) What are the potential impacts of the perceived legitimacy of healthcare workers by decision-makers on HHR decisions and how do they affect healthcare workers?
- 3) What possible measures could be implemented to mitigate the impacts of the perception of professional legitimacy in HHR policy and decision-making?

By using a mixed-methods approach of a literature review of healthcare occupational regulation and perception of professionalism, review of Case Study #1: Bills 29 and 94: Impact on Non-professional Healthcare Workers and Case Study #2: Changes to the *Health Professions Act*, and interviews with former HHR decision-makers, a series of themes are revealed. A phenomenological approach is used in the analysis of the information and data collected.

The analysis indicates that there may be a connection between the professional regulatory status of health workers and perception of legitimacy of these workers by decision-makers. The full list of themes from this study are found in Appendix A (p. 75), and cover a variety of topics relating to HHR, professional legitimacy, occupational regulation, professional consultation and collaboration, decision-making, and political considerations.

Based on the findings of this thesis, four recommendations for the public service are proposed to address the challenges and opportunities of health sector occupational regulation. Those recommendations are:

- **Recommendation 1:** Embed inclusive government consultation and collaboration in all major HHR policy and decision-making.
- **Recommendation 2:** Use Gender-based Analysis Plus lens to identify all impacts on healthcare workers.
- **Recommendation 3:** Integrate a public interest perspective in HHR legislation.
- **Recommendation 4:** Introduce bias training for all public servants.

Further research is warranted to examine the themes and implications of professional legitimacy in policy and decision-making. Future iterations of this work could include surveying public servants and health authority staff, use of psychological instruments to measure perception, and deeper examination of healthcare occupations – especially unregulated occupations.

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Acknowledgements

First of all, I would like to extend my deepest and sincerest thanks to my supervisor, Robert Lapper, who was the most instrumental in supporting my academic and professional endeavors. This dissertation is a result of his mentorship, unwavering encouragement, and constructive advice in the pursuit of professional excellency in the public sector. I extend my deep gratitude to my second reader Jason Hicks for sharing his knowledge, expertise, and humour that benefited this work. Both of their efforts will always continue to inspire a life-long interest for research within occupational regulation and public administration.

I would like to acknowledge the contributions of the participants in this study, who demonstrated their dedication to the public in their roles as public servants. My sincerest thanks to all the participants for their honesty and entrusting me with their experiences and perspectives.

I was lucky to have been part of a diverse and brilliant cohort of classmates. Thank you to all, including Andrew Prosser, Kira Craig, Meghan Corbett, and Sarah Greer for all the laughter and support through this journey.

I would also like to acknowledge those who were instrumental in my professional development in the public service. John Stylianou and Melody Chilibeck, and all whom I had the privilege to learn from at the Ministry of Health. Bowinn Ma, friend and mentor, Shideh Javadi, and the many passionate activists. Sally Breen and the wonderful team at Vancouver Coastal Health for the support and encouragement.

My friends who helped me through thick and thin, near and far, including Rosemary Preckel, Jessica Margovskiy, Lydia Tang, Movie Club, Khalid Boudreau, and many others who stayed connected one meme at a time. And of course, my dog, Charlie who put up with the hours spent studying and not playing fetch.

Last but certainly not least, my parents Halina and Roman Bilinski. Thank you for doing all that you could so I could pursue this journey, even when it was the most difficult of circumstances.

You mean the world to me.

Dedication

This work is dedicated to those we have lost over my time pursuing this project:

- Michael Parasuik: devoted activist and public servant, and quick-witted mentor,
- Marcelina Perdido Agulay: compassionate friend, and advocate for migrants and workers,
- Jimmy Bilinski: four-legged pal, who left paw prints on my heart,
- Władysława Poźniak: grandmother, resilient matriarch, and survivor of war.

work for health and care

arrival to new foreign homes,
with accents thick of experience and perspectives.

promises of milk and honey,
reality curdles the recognition of their degrees.

no clear path in the new land.
no voice at this new bottom.

you are a recognized as a hero,
but only when others would not take your job,
or when the whole world locks down.
Heroic are those on the front-lines, battling the longing for a familiar home.

bringing health to strangers,
for the survival of family and loved ones.

caring work to ensure their children,
may at least be the ones thriving - sweet and rich with recognized experiences.

Chapter 1: Introduction

Citizens worldwide banged pots and pans to demonstrate appreciation for front-line healthcare workers in the summer of 2020. The public recognized the hard work of front-line workers and respected workers' efforts to keep the health system going in times of crisis. Front-line healthcare workers refer to allied health, medical staff, nursing, and other roles that provide care in acute, community, long-term care, and other patient-facing environments. The barriers and issues faced by allied health, nursing, and medical professionals are well-studied (Schonfelder & Nilsen, 2016). Non-professional healthcare occupations, which are mostly unregulated, include various health support workers, such as health care assistants (HCAs), housekeepers, and dietary aides. Furthermore, non-professional healthcare workers provide support to healthcare professionals.

Health human resources (HHR) include clinical and non-clinical staff responsible for public and individual health interventions and, as some argue, are the most important inputs to a functional health system (Kabene et al., 2006). Policy and decision-makers are public servants who set strategies and legislation that shape HHR policies, including professional and occupational regulations. Regulatory status refers to whether an occupation is regulated by a professional or regulatory body. Professional and occupational regulations also influence the professional legitimacy of healthcare occupations by granting occupations some recognition as a distinct profession and authority to self-regulate in some jurisdictions (Balthazard, 2015). Typically, non-professional occupations are also unregulated in most jurisdictions and understudied in the academic literature (Schonfelder & Nilsen, 2016). In contrast, many regulated professionals benefit from the strong advocacy or professional legitimacy that results from their professional designation (Aldridge, 2008; Bryson & Kleiner, 2010; Larson, 1979; Ravesteijn et al., 2016; Timmons, 2011). These differences between regulated and unregulated occupations expose a hierarchy of healthcare workers and potential advantages for professionals, such as professionals' advocacy better received by policy and decision-makers. Given the other significant pressures on HHR (e.g., high vacancies and turnover as well as recruitment and retention issues), access to the best available information is required for policy and decision-makers to equitably analyze research and decide in the public's best interest to counteract issues caused by a hierarchy of healthcare workers (Aldridge, 2008; Wranik, 2007).

This thesis examines decision-makers' perceptions of professional legitimacy of occupations by focusing on unregulated healthcare workers, a population typically overlooked or downplayed within health human resource literature. The limited scope of HHR literature and its knowledge of unregulated healthcare occupations create challenges to developing and planning policies and decisions. For this research, health occupations refer to paid employment roles in health care that provide front-line services. This definition includes regulated, unregulated, professional, and non-professional roles in private or publicly funded care settings. This study will bring attention to the experiences of healthcare workers concerning their occupational regulatory status, as well as the perspectives of HHR decision-makers. This thesis also examines the potential implications of decision-makers attending to particular healthcare occupations.

1.1 Research Question, Objectives, Rationale

This research focuses on the topic of the perception of professional legitimacy of unregulated occupations in the HHR sector in British Columbia (B.C.), Canada. This work aims to identify whether the occupational regulatory status of healthcare workers influences decision-

makers' perception of the professional legitimacy of their respective occupations, and the potential implications on HHR policy. The following questions ask how decision-makers perceive healthcare workers' regulatory status and the influence of occupational regulation.

The research questions of this study are:

- 1) Does the occupational regulatory status of healthcare workers impact their perceived legitimacy (defined in section 1.3 Glossary, p. 7) by decision-makers in B.C. HHR policy decision-making?
- 2) What are the potential impacts of the perceived legitimacy of healthcare workers by decision-makers on HHR decisions and how do they affect healthcare workers?
- 3) What possible measures could be implemented to mitigate the impacts of the perception of professional legitimacy in HHR policy and decision-making?

These research questions are answered using an exploratory approach to identify key themes in two case studies and a phenomenological research method for interviews with former B.C. HHR decision-makers. The two case studies, Case Study # 1: Bills 29 and 94: Impact on Non-professional Healthcare Workers, and Case Study #2: Changes to the *Health Professions Act*, were selected to map themes from the literature onto specific cases of HHR decision-making and its affects on healthcare workers. Using a phenomenological approach for interviews allows former decision-makers to speak directly to their perspectives and respond in ways not strictly limited by structured questions. These research approaches allow for further discussion on these significant cases and the perspectives of decision-makers on this topic.

1.2 Defining the Issue and Scope

Occupational regulation has become a topic of public interest, especially in the health sector, given the growing workforce pressures on HHR and increased complaints about the conduct of healthcare professionals (Cayton, 2018; Leslie et al., 2021). While some professionally regulated occupations and their members have been scrutinized by the public for their unprofessional behaviour, the former hold more influence and professional privileges than unregulated healthcare workers. These privileges are important in influencing decision-makers and subsequently HHR strategies and policies (Busuioac & Lodge, 2017; Contandriopoulos, 2011; Graddy, 1991).

Questions regarding who and how to regulate continue as health occupations evolve. In Canada, healthcare professionals are regulated through provincial legislation (e.g., the B.C. *Health Professions Act*). However, these laws often become outdated because they cannot keep pace with the technological advancements, services, and client demands (Susskind & Susskind, 2015). Such challenges further complicate the roles of decision-makers to determine what is in the best interest of patients due to outdated laws and availability of information, and patient demands for health services (Care, Steel & Wardle, 2021). In this study, two case studies are examined to highlight the challenges of outdated legislation and occupational regulation, and interviews with decision-makers are introduced to demonstrate the challenges associated with regulation and HHR decision-making.

Finally, it is a common statutory requirement that regulation is meant to protect public interest. One of the core theories informing occupational regulation is Public Interest theory. It argues that government regulation protects the public's interest, improves the quality of services, and protects the safety of patients (Scheffler & Nunn, 2019). A counter to Public Interest theory is Public Choice theory. According to Public Choice theory, occupations are regulated out of the

self-interest of practitioners because regulation may reduce competition and increase occupational wages (Scheffler & Nunn, 2019). Scepticism has grown among the public due to many examples of professional associations strongly advocating for and influencing changes within regulatory colleges that largely serve the interests of occupational practitioners (Cayton, 2018; Cayton, 2015). Especially within the healthcare sector, occupational practitioners fight to be regulated as it is a fundamental step to achieving professional status and legitimacy (Dill et al., 2022; Ravesteijn et al., 2013; Timmons, 2011). Therefore, separating information on what is in the public’s interest and what primarily serves the interests of occupations is a challenging balancing act for decision-makers.

Within the scope of this research are regulated and unregulated healthcare occupations that provide clinical and non-clinical care for patients, as well as B.C. provincial, public, sector political, and executive decision-makers who set HHR strategies. These decision-makers include political decision-makers (e.g., Ministers and Deputy Ministers) and non-partisan public service employees (e.g., Assistant Deputy Ministers, Executive Directors). This cohort is of interest due to their role in setting HHR strategies and decisions on occupational regulation and policy. Within the scope of this research is theory and evidence from the literature on professional legitimacy, decision-making, public service policy, health professional associations and labour unions, as well as the B.C. Health Human Resource Strategy and HHR policy.

1.3 Glossary

Health Occupations: Health occupations refer to paid employment roles in health care that provide front-line care in healthcare settings. This definition includes unregulated, and non-professional roles in private or publicly funded care settings (Statistics Canada, 2018).

Health Professionals: Health professionals are healthcare workers in roles that require a professional designation, typically received from a regulated body or organization. Some health professionals can be identified easily by having “registered,” “licensed,” or “certified” in their job title, like a registered dietician or licensed practical nurse (Balthazard, 2015; Thompson, 2016). Each province and territory sets standards and requirements for attaining a professional designation. Health professionals also must be registered with their regulatory college and abide by professional standards and scope of practice. Some health professionals will oversee and supervise unregulated occupations as part of their responsibility (Thompson, 2016). A comparison between health occupations and professionals can be found in Table 1.

Table 1. Comparison Chart (adapted from Surbhi (2018))

	Occupation	Profession
Definition	Regular activity undertaken by persons to earn an income.	Vocation that requires specialized training, knowledge, qualification, and skills.
Code of Conduct	No	Yes
Training	None or Limited	Yes
Regulated	No	Yes
Basis of pay	Service output	Skill, knowledge, service output
Higher education	No	Yes
Self-Regulating	No	Yes
Degree of independence	None	Full independence
Respect and Status	Low	Very high

Regulated Profession: The concept of regulated profession is fundamental to this research, as it demonstrates the key differences between health occupations and professions. A regulated profession is an occupation that has a governing or regulatory body that is sanctioned by law to govern or regulate the profession; being recognized by the state in this way is commonly seen as the line between being a self-declared profession and a legitimate profession (Balthazard, 2015; Pynes & Lombardi, 2012; Thompson, 2016). According to Public Interest theory, governments regulate occupational activities to ensure services are in the public interest and this regulation of activities can be considered as consumer protection (Bryson & Kleiner, 2019; Bryson & Kleiner, 2010; Kleiner & Kruger, 2010). Professional self-regulation is the highest level of trust and legitimacy a state can have for an occupation. It follows from the philosophical foundations of professionalism, which has a solid commitment to an ideology of service. Section 92 of the *Constitution Act 1867* (Canada) grants provinces the authority to make laws regulating professions and determines which occupations are regulated and in what ways. The substance and process of professional regulation varies between provinces (Balthazard, 2015). In Canada, many professions are self-regulated, meaning that professions have been given some powers that normally only governments control, such as determining entry qualifications, registration, and continuing education requirements (Competition Bureau, 2007). This model allows the government to maintain some control over the practice of a profession and the services provided by its members by delegating regulatory authority to a self-regulating professional body. It eliminates the need for the government to possess the specific expertise required to regulate the profession directly and limits government oversight of the occupation. This also may limit the government's ability to directly determine qualifications and other barriers to entry into the profession.

Regulation of professional occupations can take three forms; these forms are registration, certification, and licensure. Registration is the least active form of regulation, requiring professionals to be listed on a sanctioned register. Certification is the approval given to an individual for meeting pre-determined requirements and is often associated with a monopoly use of a specific title or designation (i.e., the protection of title). Providing information about the designation holder's qualifications allows the public to make informed decisions of who has professional competency. Licensure is the most restrictive form of professional regulation since it provides an occupation group with monopoly control over who can practice in their profession. Only licensed individuals can practice the profession or perform controlled acts. There are also particular entry requirements, often including attaining specified educational requirements and successful completion of a licensing examination (Balthazard, 2015). The restriction on who can hold the title of regulated professional adds to the exclusivity of the professional designation. This restriction further strengthens the power of those occupations that are regulated and are higher on the hierarchy of healthcare occupations.

Professional regulation in Canada falls under the jurisdiction of the thirteen provinces and territories, and it is difficult to universally define and capture the criteria for professional regulation and the multiple tiers of regulatory status, especially in the Canadian context (Thompson, 2016). However, the theme is consistent that professional regulation, in all models and forms, in exchange for regulatory powers, is expected to operate in the public interest, protect the public from incompetent or unethical practitioners, and ensure the adequate provision and access to professional services. In short, while some occupations strive to be professionally regulated, the motivations cannot be self-serving to the occupation (e.g., increase its legitimacy),

and the priority cannot be to forward the self-interests of the profession and its members (Balthazard, 2015).

Professional Associations and Professional Regulatory Bodies: Both professional associations and professional regulatory bodies have related but distinct purposes in the professional regulation of occupations. The core difference is that professional associations serve their members' interests, while professional regulatory bodies serve the interests of the public (Balthazard, 2015). In this research, professional associations and regulatory bodies are key components that may elevate the professional legitimacy or image of a healthcare profession.

By law, professional regulatory bodies are required to protect and promote the public interest by regulating the profession's practice and minimizing and mitigating risks to the public (Bryson & Kleiner, 2010). Other core responsibilities of regulatory bodies are defining criteria for registration with and certification by the professional regulatory body; guiding members in the form of codes of ethics, professional conduct rules, and practice standards; maintaining a public register containing information about individual members; and investigation of complaints about members and carrying out disciplinary action when required (Balthazard, 2015).

Professional associations have no statutory requirements and are established to serve their members' interests. This includes providing activities not limited to networking opportunities; public information of interest for their members; research; staging of conferences, seminars, and workshops; maintenance of job boards; negotiation of preferential wages for members; and lobbying governments to influence policy to further members' interests (Balthazard, 2015). Professional associations may be difficult to identify due to the public presentation of their organization. Furthermore, professional associations are like labour unions as they primarily serve the interests of their members and partake in very similar activities.

Most often, professional associations and regulatory bodies are separate, but this may not always be the case (Cayton, 2015; 2018). When they are not separate, the risks of conflicts of interest can be significant. This may be permitted, typically for newly regulated or small professions. These organizations are called dual-object professional bodies. Most often, the members' and public interests are the same, especially within public healthcare settings (Ombudsman British Columbia, 2003). However, professional regulators may set practice limits and boundaries on members' behaviours that the professional association may perceive to be burdensome and too restrictive (Ombudsman British Columbia, 2003). Dual-object professional organizations will always carry the risk of regulatory capture, where regulators identify with and advance the interests of the regulated over the interests of the public (Balthazard, 2015).

Types of Healthcare Occupations: Front-line healthcare workers can fall into four distinct categories of occupations: allied health, medical staff, nursing, and health support workers.

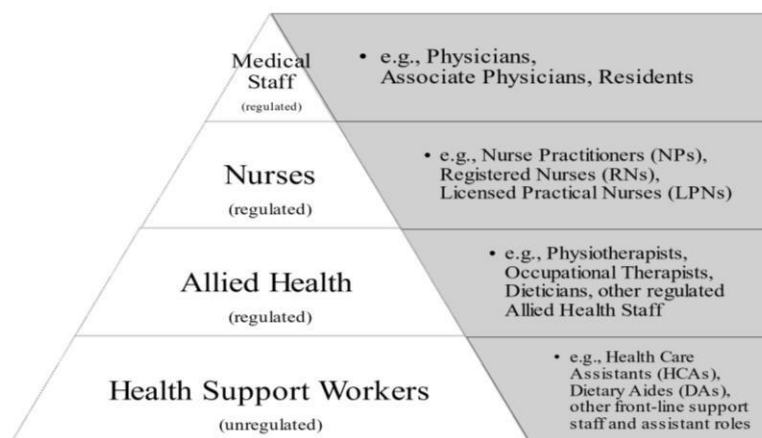
- ***Allied Health:*** Allied Health refers to a broad group of health occupations that are distinct from medicine and nursing. Allied health occupations are involved with the delivery of healthcare services including the identification, evaluation and prevention of disorders and diseases, dietary and nutrition services, rehabilitation and health systems management, and many others. Over 70 allied health occupations, comprised of regulated and unregulated occupations, work in technical, social/community, clinical and therapy settings in B.C. A few examples of regulated allied health occupations include dental hygienists, psychologists, dietitians, occupational therapists, physical therapists,

perfusionists, naturopaths, and traditional Chinese Medicine practitioners (Allied Health Policy Secretariat, 2022).

- **Medical Staff:** Medical staff refer to medical professionals that are occupationally regulated and require intensive formal education and credentialing requirements. In B.C., medical staff are regulated by the Medical Practitioners Regulation and the College of Physicians and Surgeons of British Columbia (Medical Practitioners Regulation, 2008). Medical staff include occupations like specialist physicians, general practitioners, and dentists.
- **Nursing:** Nursing refers to health professions that provide the following health services: care for the promotion, maintenance, and restoration of health; prevention, treatment and palliation of illness and injury by assessing health status, planning, and implementing interventions; and coordinating health services (Nurses Registered and Nurse Practitioners Regulation, 2008). This includes regulated occupations such as licensed practical nurses (LPNs), nurse practitioners (NPs), registered nurses (RNs), and registered psychiatric nurses (RPNs). For the purposes of this thesis, midwives are also included in the nursing category because in B.C. this occupation fall under the scope of nursing policy (B.C. College of Nurses and Midwives, n.d).
- **Health Support Workers:** Health support workers refer to healthcare occupations that assist patients and support the work of a regulated healthcare professional, with relatively limited training or formal education. Health support workers are a variety of unregulated occupations that work under the supervision of a regulated healthcare professional. For this thesis, health support workers refer to roles such as rehabilitation assistants, dietary aides, health care assistants, and housekeepers.

Occupational Hierarchy: Occupational hierarchy refers to the stratification of healthcare occupations by power and influence. Occupations that are higher on the hierarchy are regulated professionals, highly educated and credentialed, and hold greater responsibility over patient health outcomes (Bourgeault & Mulvale, 2006; Dill et al., 2022; Employment and Social Development Canada, 2022). Throughout this research, occupational hierarchy is a fundamental concept and a phenomenon observed in the case studies and interviews. Figure 1 depicts a non-extensive list of front-line healthcare staff and where they are be situated on the hierarchy. This hierarchy is further examined in Chapter 2.5.

Figure 1. Health occupational hierarchy



Legitimacy & Professional Legitimacy: For this research, the concepts of legitimacy and professional legitimacy are important as they are the main variable of interest. Both concepts are found in the literature to be critical factors in the creation of perceptions about an occupation and are influenced by occupational regulation.

- **Legitimacy:** Legitimacy means social credibility and acceptability: “a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions” (Black, 2008, p. 144). Legitimacy may be subjective, yet socially constructed by the norms and customs of the society. In a regulatory context, to be legitimate means that an occupation is perceived as having a right to govern and act for its members and the people they serve. Occupational organizations may claim legitimacy and perform work and enter relationships with other organizations to gain it; however, legitimacy is rooted in the acceptance and perception of others and the reasons for that acceptance (Black, 2008).
- **Professional Legitimacy:** Professional legitimacy is a multifaceted construct the existence of which is linked to a profession’s socio-economic relevance. Relevance is related to expectations regarding the scope of knowledge required of members, individual competencies, and market and social considerations (Beaulieu, 2002; Tidmarsh, 2022). Professional legitimacy is derived from state-approved jurisdiction over a particular activity, mastery of specific knowledge learned through prolonged education and training, socio-economic and technical autonomy over work organization, and a client-centred ideology of service (Susskind & Susskind, 2015; Tidmarsh, 2022). These conditions are the fundamental requirements for professional legitimacy and affect these societal perceptions and norms of an occupation. As Susskind and Susskind (2015) describe, professionals are bound by regulations and regulatory bodies that ensure a high standard of the work they deliver. In the context of this study, health professionals in B.C. are defined by the *Health Professions Act*, which further outlines duties and responsibilities and references other legislation that sets out the creation of regulatory organizations that further legitimize professions. Health professionals may be permitted to delegate work to unregulated occupations, but that does not transfer their professional legitimacy to these occupations (Thompson, 2016).

1.4 Structure of Thesis

The subsequent chapters of this thesis contextualize and examine research evidence. Chapter 2 consists of the literature review including the relevant themes and concludes with the conceptual framework. Chapter 3 covers the background on occupational and professional HHR regulation. In Chapter 4 the methodology and data collection methods used for this thesis are stated. Chapter 5 identifies the findings of Case Study # 1: Bills 29 and 94: Impact on Non-professional Healthcare Workers, Case Study #2: Changes to the *Health Professions Act*, and findings from interviews with former HHR decision-makers. In Chapter 6, the discussion and analysis explore the emergent themes and address the research questions and findings relevant to decision-making. Finally, this thesis will conclude with Chapter 7 with recommendations for HHR policy and decision-making to mitigate the impacts of occupational regulatory status.

1.5 Positionality Statement

In the spirit of self-reflexivity in this academic work, I acknowledge my standpoint as a first-generation Canadian, born to parents of the Eastern European diaspora, settled on the

unceded and occupied territory of the Coast Salish peoples – Squamish, Tsleil-Waututh, and Musqueam Nations (also known as Vancouver, B.C.). I have witnessed, from a young age, as the daughter of a non-clinical health support worker and raised in a community of healthcare workers, the hard work of professionals and non-professionals who have spent countless hours advocating for their status and labour rights. I also hold the privilege of formal higher education in the social sciences (Political Science, Psychology, and Public Administration) and professional experiences as a public servant within formal institutions of power in roles that inform decision-makers who impact healthcare policy and direction. My positionality influenced my interest in such a topic, my access to information and knowledge in this area of study, and the humility required to respectfully address all the essential roles of all healthcare workers.

Chapter 2: Literature Review

This chapter reviews the literature on the perception of the professionalism of unregulated healthcare workers by decision-makers and draws in other thematically relevant concepts. These themes yield an overview of common challenges and beliefs in professional regulation. Themes found throughout the literature and research are compiled in Appendix A – Thematic Matrix on p. 75. This chapter concludes with the conceptual framework for this research that links the themes discussed in this chapter.

2.1 Introduction

There exists limited literature exploring the perception of professional legitimacy, particularly within the context of unregulated healthcare occupations. The literature that exists primarily draws upon the broader literature on occupational regulation. Occupational regulation has attracted academic interest across disciplines, with roots tracing back to influential figures like Adam Smith (1937) and Milton Friedman (1962). This enduring fascination stems from the fundamental challenge of balancing freedom and order, a task crucial for democratic governments. This imposition of occupational regulation, however, may curtail the freedoms of occupations and their members (Bryson & Kleiner, 2010). Two key theories – Public Choice and Public Interest – are central to the purpose of occupational regulation in this body of literature. Additionally, the discussion delves into the concepts of culture and hierarchy, emphasizing the influential forces that shape the perception of certain healthcare workers. The critical role of government and decision-makers in shaping HHR policy, their relationship with healthcare occupations, and the associated perception of professional legitimacy is also explored.

2.2 Literature Retrieval Methods

The University of Victoria online library databases were used for this literature review. The academic databases accessed include JSTOR, Google Scholar, Academic Search Complete (EBSCO), eBook Collection (EBSCO), Health Source – Consumer Edition, Health Source – Nursing/Academic, Science Direct, and Cambridge Journals Online. Various search terms were used to locate articles relevant to the research topic. Prominent search terms include “professional regulation,” “occupational hierarchies,” “professional hierarchies,” “healthcare occupations,” “professional legitimacy,” “perception of legitimacy,” “decision-maker,” “health human resources,” “Public Choice theory,” “Public Interest theory,” and “unregulated”. The literature review has peer-reviewed articles published since 1986, most published since 2003.

2.3 Themes of the Literature Review

2.3.1 Public Choice

Public Choice theory in occupational regulation is a political economy theory that seeks to explain how government officials make decisions and suggests that the regulation of specific professions is frequently influenced by special interest groups and rent-seekers who desire to restrict competition to increase their own profits (Scheffler & Nunn, 2019). Public Choice theory argues that occupational regulation is often driven not by concerns for public safety or quality of services, but instead to benefit practitioners (Scheffler & Nunn, 2019). This motivation is due to the desire of those already in the profession to limit competition and maintain their status and power, increase their professional legitimacy, and exclude unscrupulous practitioners from the profession (Scheffler & Nunn, 2019; Timmons, 2011). The regulatory status of an occupation

can significantly influence the perception of decision-makers by making decision-makers more likely to listen to practitioners in an occupation, and one theory that helps explain this is Public Choice theory. Public Choice theory is foundational, and may answer what shapes decision-makers' perspectives in relation to the impact of regulatory frameworks on their decision-making processes.

2.3.2 Public Interest

Public Interest theory is counter to Public Choice theory, and suggests that there is a need for occupational regulation in certain industries, such as health care, to protect the health and welfare of the public (Scheffler & Nunn, 2019). The theory provides a framework for decision-makers to balance the interests of consumers and businesses and suggests that occupational regulation can lead to mutually positive outcomes for both the public and regulated professionals (Graddy, 1991).

2.3.3 Purpose of Occupational Regulation

The purpose of occupational regulation is generally understood to regulate public safety and mitigate risks of poor quality of care, as well as to standardise qualifications and training. However, some scholars argue that government decision-makers and politicians may have other motives to regulate professions that serve their own interests (Scheffler & Nunn, 2019; Timmons, 2011). Regulators and politicians have their own self-serving interests, such as the desire to maintain power, limit competition, provide for their supporters (e.g., special interest groups), and uphold their mandates and political strategies (Kleiner & Kruger, 2010; Gallo-Cruz & Rutherford, 2011; Givati et al., 2018). Consumers and clients are at higher risk of suffering health and safety costs when there is no regulation and in circumstances when they lack information necessary to accurately assess service and quality (e.g., the spread of infectious diseases or pandemics), and should be protected with tools like regulation (Bryson & Kleiner, 2019, p. 726).

According to Public Interest theory, the reasons governments regulate certain professions are many. Reasons for regulation include providing a way for professions to uphold ethical and professional standards; Ensuring that professionals meet some minimum qualifications, standards of practice, and codes of conduct; ensuring that services provided to the public are safe and effective; protect patients from incompetent, unethical, or fraudulent professionals; Leveling the playing field for organizations and individuals operating within a specific occupation, and increasing the public's access to these organizations and services, through the creation of regulatory bodies (Bryson & Kleiner, 2019, 2010).

2.3.4 Interests of Occupational Regulation

Both the public and occupations have strong interests in occupational regulation since those interests often align with public health and safety. Occupational regulation under Public Interest theory focuses on what is in the public's interests, and that includes the reduction of inadequate services, misconduct, or fraud (Graddy, 1991; Scheffler & Nunn, 2019). Regulation can give certain occupations recognition, credibility, political influence, and greater professional legitimization (Aldridge, 2008). Finally, occupational regulation also acts as a form of consumer protection, giving the public access to impartial mechanisms, such as regulators and regulatory bodies, for grievances when they have concerns about services provided or the conduct of a professional (Bryson & Kleiner, 2010).

The public has a strong interest in occupational regulation as well, and those interests may align with the self-interests of politicians and decision-makers. Occupations also have a self-interest in being regulated, to gain advantages such as protection over their scope of practice, skills, and claim to knowledge. That protection over scope of practice, skills, and claim to knowledge increases the prestige or professional legitimacy of the occupation. Occupational regulation can restrict the number of entrants into a profession, and therefore increase the wages of professionals (Gallo-Cruz & Rutherford, 2011; Givati et al., 2018; Kleiner & Kruger, 2010).

2.3.5 Advantages of Occupational Regulation

Proponents of occupational regulation argue that it offers benefits to consumers, professionals, and society. By setting minimum standards and qualifications, regulation can enhance the quality of services provided by professionals, while also creating a level playing field and mitigating risks associated with unscrupulous practitioners (Leslie et al., 2021). Furthermore, occupational regulation can serve as a deterrent to illegal and unethical activities with the presence of regulatory bodies and enforcement mechanisms (Bryson & Kleiner, 2010).

According to Public Interest theory, the advantages of occupational regulation extend to the enforcement of standards and codes of conduct in professions, such as physicians and registered nurses that have a significant impact on public welfare (Bryson & Kleiner, 2010). Regulation can also contribute to improved working conditions and better pay in certain professions, particularly those that are low-paid, labour-intensive, or high-risk (Bryson & Kleiner, 2019). These improvements often result from the advocacy efforts of organized representative groups, such as professional associations, which work to influence decision-makers responsible for setting HHR policy.

2.3.6 Disadvantages of Occupational Regulation

Occupational regulation, in public choice theory, has several disadvantages. It limits consumer choice, increases service costs, and stifles innovation and entrepreneurship (Currie & White, 2012; Graddy, 1991; Scheffler & Nunn, 2019). Barriers to entry created by regulation restrict competition and shield established professionals from fresh perspectives and innovative approaches (Dill et al., 2022). Such barriers disproportionately impact individuals from historically disadvantaged groups, including internationally educated professionals and those with low socio-economic status (Dill et al., 2022). In addition, occupational regulation imposes costs on professionals and organizations, leading to higher fees and reduced market competition (Bryson & Kleiner, 2019; Kleiner & Krueger, 2010; Leslie et al., 2021). It creates bureaucratic hurdles that hinder innovation and can be captured by interest groups, resulting in ineffective oversight (Timmons, 2011). Moreover, established professionals may use regulation to restrict competition and prevent newcomers from entering the market (Aldridge, 2008; Bryson & Kleiner, 2019; Leslie et al., 2021), leading to higher prices and limited access to services. These disadvantages warrant careful consideration by decision-makers to ensure that the benefits of occupational regulation outweigh the costs.

2.3.7 Culture & Hierarchies

Culture and hierarchies in the healthcare sector are influential. Due to the complexity of the healthcare system with an array of healthcare workers with various practice requirements, there is a hierarchy of healthcare workers. Hierarchies, while having a negative connotation, can be positive and helpful in fast-paced and complex environments as they assist with the

management of workloads and assignment of responsibilities. However, hierarchies can also create tensions within the system and in healthcare teams.

Some challenges linked with culture and hierarchy are seen in the Canadian healthcare sector, including HHR policy, due to high reactivity when a crisis emerges (Marchildon et al., 2021; Wilson, 2013). When systems are in a reactive state it may make it easier for one entity or group to dominate the discourse and monopolize attention around a particular topic.

Furthermore Wilson (2013) and others argue that medical staff do not dominate the discussion on HHR; others who study the occupational hierarchies and policies do not agree (Currie & White, 2012; Dill et al., 2022; Heiss et al., 2018; Kinder, 2020). Such influence can shape HHR policy and affect the policies and regulations of other occupations that overlap with their scope of practice (Contandriopoulos, 2011; Currie et al., 2020; Currie & White, 2012; Franco & Tavares, 2013). Occupations can influence the scope of practice of other occupations when consultations occur over policy impacts on shared regulated tasks and responsibilities.

Authority: Hierarchies and the hegemonic power wielded by those at the top can have detrimental effects on individuals positioned lower in the hierarchy, creating formidable barriers to their occupational advancement. Bryson and Kleiner (2019) highlight that individuals who face relative disadvantages within their professional field are more likely to support the certification of their occupation (p. 728). Furthermore, other scholars emphasize the importance of considering power dynamics within social structures in policy development, particularly in relation to intersectional impacts and identities that contribute to adverse healthcare outcomes for both patients and staff (Logan, 2019; Hankivsky, 2014; Ravesteijn et al., 2013).

Access to Resources: The healthcare sector is highly regulated, and workers operate within a complex hierarchy that can dictate access to resources (Logan, 2019; Sanders et al., 2008; Wranik & Haydt, 2018). For example, nurses and physicians occupy different levels of authority and responsibility. Nurses may have less influence in decisions related to clinical and patient care, allocation of resources, and policies compared to physicians. Occupational regulation can also impact the access to resources, and scopes of practice. Regulatory bodies require certain tasks to be only performed by specific health professionals, which can restrict access to care for patients – especially in underserved, rural, and remote communities (Sanders et al., 2008). Although various healthcare occupations may possess the necessary skills and knowledge to provide care and be part of the care team, the regulatory framework influences and solidifies the existing hierarchy within the healthcare system.

In fall 2022, the B.C. Ministry of Health released the “B.C.’s Health Human Resource Strategy” (B.C. HHR Strategy) outlining 70 different actions to support the retention, redesign, recruitment, and training of healthcare workers (Ministry of Health, 2022). The strategy is guided by seven principles: putting people first; service focus; Indigenous health and reconciliation; diversity; equity, and inclusion; sustainability and innovation; collaboration; and evidence-informed decision-making (Ministry of Health, 2022, p. 10). All actions have been examined using a Gender-based Analysis Plus (GBA+) and Indigenous cultural safety lens, and include specific actions to “fully implement and integrate equity and GBA+ into the health sector” (Ministry of Health, 2022, p. 33). The Strategy also touches upon all unregulated and regulated healthcare occupations; however, there is an underrepresentation of actions directed at the supporting of unregulated occupations. This highlights that there are differences between the

health occupations regarding the access and attention they receive from HHR policy and decision-makers.

Attention to Certain Occupations: HHR literature pays greater attention and depth of research covering professional occupations than it does to unregulated occupations (Kleiner, 2000). For example, the HHR literature has dedicated journals and fields of study for nurses that are more expansive than for HCAs.

This may be due, in part, to higher skilled occupations and the clinical care they provide being more responsible for patient care outcomes. In essence, regulated healthcare professionals have a larger impact on individual health outcomes. While that is true, there are other unregulated occupations that without their work critical care cannot be provided.

The scarcity of attention and resources these unregulated health occupations have can lead to significant implications, such as overlooking the affects of HHR policy on unregulated occupations (Logan, 2019; Sanders et al., 2008; Wranik & Haydt, 2018). The lack of focused attention on unregulated health occupations may increase their reliance on ideologically affiliated organizations (e.g., labour unions and professional associations) for advocacy. This reliance on ideologically affiliated organizations contrasts with allied health professionals, medical staff, and nurses who have representation in academic research to validate their advocacy efforts and establish their legitimacy. This can also lead the well-established regulated professions, with their complex structures and systems, to be highly influential at the expense of those with fewer indicators of professionalism (Bates et al., 1986; Dussault & Dubois, 2003).

2.3.8 Professional Legitimacy

Professional legitimacy in the literature is a concept that potentially influences the perception of the credibility of information, especially for HHR policy (Bryson & Kleiner, 2010; Kleiner & Krueger, 2010; Kleiner et al., 2011; Larson, 1979; Quick, 2011; Sutherland & Leatherman, 2006; Tidmarsh, 2022; Timmons, 2011). Some scholars suggest that there could be a strong link between professional legitimacy and decision-making processes (Franco & Lawrence, 2014; Heiss et al., 2018; Larson, 1979). Studies suggest that professional legitimacy influences the degree to which healthcare workers are perceived as credible sources of information, which may influence how decision-makers approach healthcare issues and create policies (Quick, 2011).

Professional legitimacy in health care is based on several factors. These factors include: the knowledge and expertise of the healthcare worker, their adherence to ethical and professional standards, and ability to communicate effectively with others (Tidmarsh, 2022). Studies have shown that healthcare workers with higher-levels of professional legitimacy are more likely to be trusted by patients, managers, and decision-makers, resulting in increased influence on the decision-making process (Tidmarsh, 2022; Timmons, 2011). Some studies have explored the influence of professional legitimacy on healthcare policy and suggest that healthcare workers with lower-levels of professional legitimacy may struggle to gain attention, influence policy decisions that affect their works, and gain support for their ideas (Busuioc & Lodge, 2017; Dill et al., 2022; Logan, 2019).

Other scholars suggest that professional legitimacy is important in the context of contentious policy debates, including those in HHR policy or the use of new technologies in the healthcare sector (Susskind & Susskind, 2015). In these cases, healthcare workers with high

degrees of professional legitimacy may have been better positioned to influence policy discussions and shape decision-making processes (Quick, 2011). These cases raise questions and concerns regarding equity among healthcare occupations, and whether some healthcare professionals may have too much authority or say in HHR decision-making (Busuioc & Lodge, 2017; Sutherland & Leatherman, 2006).

Reliance on Professional Legitimacy: According to the literature, decision-makers in the healthcare sector rely on professional legitimacy because they often depend on the experience and expertise of healthcare professionals to inform their decisions (Busuioc & Lodge, 2017; Coburn, 1993). Professional legitimacy sometimes is the basis for trust and credibility in healthcare decision-making, and professionals with higher-levels of professional legitimacy are often considered to be the most authoritative and credible sources of information (Dussault & Dubois, 2003). Healthcare professionals and groups help policy and decision-makers to create guidelines, standards, and policies, and as a result help promote professional education, training, and standards of care.

2.3.9 Government & Decision-Making

Government decision-makers are critical actors in the setting of strategies and policies in health care. They are also influenced by many factors when it comes to their decision-making, and one of those factors may include the influence of professional legitimacy. While the literature is limited with respect to an explicit link between professional legitimacy and decision-making in the healthcare sector, there are key findings suggesting that there is an important interplay.

Legislative Processes & Constraints: Due to the fragmented and complex structure of the Canadian healthcare system, legislative processes are another major factor for decision-makers for HHR policy. Provinces are responsible for HHR policy. The great variety of provincial and territorial jurisdictions is one of the reasons why there are great differences in strategies and regulations for addressing HHR challenges (Marchildon et al., 2021; Thompson, 2016). The legislative environment is also complex as provincial decision-makers must navigate the influences of the federal *Canada Health Act*, other provincial labour acts and regulations. This complexity can create competing priorities and constraints limiting the ability to enact HHR policies. However, occupations are regulated through legislation. This makes legislation one of the most important components that determine the degree to which an occupation has professional legitimacy.

Role of Decision-makers: Government enacts occupational policies and regulations that restrict the scope of practice of healthcare professionals which increases the professional legitimacy of a healthcare occupation, and the perception of professional legitimacy may influence government decision-makers. A decision-maker must examine the information presented to them and take politics into consideration when making a decision. Partisan decision-makers (such as Ministers), the provincial government, including its political and public service staffers, significantly shape strategic HHR policy, including operational policies delegated to health authorities and worksites (Cull, 2016; Marchildon et al., 2021; Thompson, 2016).

Some argue that policymakers seek to build regulations and HHR policies around patients, rather than around professions (Currie & White, 2012). The premise for occupational regulation is to protect the public, as discussed in Chapter 1. However, multiple studies and

examinations call into question whether the outcomes of occupational regulation improve patient care and access to health services or serve a particular occupation and association (Cayton, 2018; Contandriopoulos, 2011; Graddy, 1991; Larson, 1979; Schonfelder & Nilsen, 2016). There is an ongoing debate over how policymakers use occupational regulation and whether the intended outcomes to improve the patient experience occur.

Decision-maker Challenges: Decision-makers also have a unique role in mitigating potential risks and answering concerns brought up by special interest groups when occupational regulation cases emerge and impact scope of practice of occupations (Belghiti Alaoui et al., 2020; Bryson & Kleiner, 2010). However, there are significant challenges to decision-makers when reacting to these groups' immediate concerns and maintaining a balanced approach to decision-making (Wilson, 2013). Furthermore, some argue that occupational and professional regulation is mostly concerned with the administrative, procedural role of regulation. Examining occupational regulation as a procedural role may underestimate the influences that affect decision-makers, including lobbyist and individual biases. Many, including Milton Friedman, questioned the role of the government and professional associations as unbiased gatekeepers and enforcers (Kleiner & Kruger, 2010, p. 677).

Another significant challenge for health policy is that political decision-makers are also tied to considerations regarding election cycles. The election cycle dramatically affects the implementation of policy. Some policies are rushed, while others impacting systemic changes may get shelved because they do not align with election priorities and timelines (Cull, 2016).

Decision-makers rely on the best information available but are also constrained by and must be responsive to the inherently political environment in which policymaking occurs. The *Canada Health Act* is the framework for provinces to determine the shape of healthcare policies and structures. The Act sets out principles and the primary objective of healthcare policy "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (*Canada Health Act*, 1985, s. 3). In Canada and B.C. specifically, decision-makers from all parties support the main principles and objective of the *Canada Health Act*. However, they will use their perceptions and ideological frames to interpret the principles (Cull, 2016).

Public Servants: Decision-makers also rely on other public servants, such as analysts and other subject matter experts within the public service, to inform decisions. Scholars such as Doberstein (2017) and Lachapelle et al., (2014) have examined public servants to see how various information sources impact these public servants' perceptions of the credibility of the information they receive from various occupational groups, and how those perceptions determine the use of that information in policy analysis and decision-making. These findings show that even the most impartial public servant is susceptible to heuristics and cues prompted by perceptions of credibility, with evidence from academic sources being the most credible, while ideological advocacy networks rated lower (Doberstein, 2017). As Dussault and Dubois (2003) discuss, professional dominance highly influences policy and may help or hinder the implementation of new policies (Dussault & Dubois, 2003, p. 10). This professional dominance is interpreted to signify that information and claims from an occupation or healthcare worker with a professional designation is highly influential in policy discussions.

2.4 Limitations in the Literature

The existing literature on occupational regulation and the perception of professional legitimacy of healthcare occupations by decision-makers has certain limitations that warrant attention. One limitation is the predominant focus on the impact of regulation on health professionals and patients, neglecting the perspectives of policy and decision-makers, as well as unregulated healthcare workers. The scarcity of studies exploring decision-makers' viewpoints and their influence on occupational regulation and professional legitimacy is a notable gap in the literature.

Another significant limitation pertains to the limited generalizability of findings due to the specific healthcare settings and jurisdictions examined. Much of the current literature concentrates on specific professions like nursing and medicine, primarily from an American perspective. Consequently, the applicability of these findings to the Canadian context may be uncertain. To gain a comprehensive understanding, further examination of regulatory policies and practices across various healthcare occupations and their impact on the healthcare workforce is needed.

Furthermore, an alternate perspective argues against the necessity of separate research for unregulated roles, suggesting that studying their regulated counterparts can adequately cover related issues because the study of the later will encompass those that report to the regulated health professional. However, it is crucial to acknowledge the variability that exists between jurisdictions, even at the local level, in terms of the services provided by unregulated occupations, such as health care assistants (HCAs), and the diverse job titles assigned to them, including care aide, personal support worker, nursing aide, and more. This diversity diffuses attention to the occupation and complicates the consolidation of information and data available in the academic literature (Banerjee et al., 2021; Thompson, 2016).

2.5 Summary

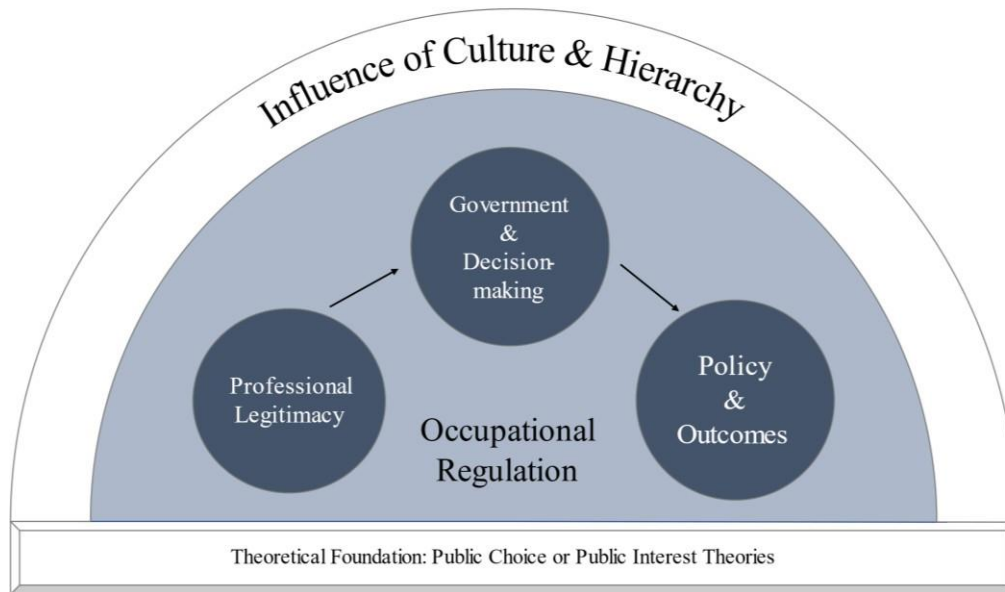
With multiple public health emergencies and workforce pressures affecting healthcare systems, HHR is a prominent topic, and more attention is being paid to professionalism and regulating health occupations. The research on the direct link between regulation and the perception of professional legitimacy is limited. However, many adjacent concepts indicate a strong relationship between the two variables. The research on occupational regulation and HHR is complex and includes various considerations and reoccurring themes. These considerations and themes highlight the different variables that influence a decision-maker's perception of a healthcare worker's professional legitimacy based on their regulatory status. A decision-maker's perception is fundamental in determining strategic and policy direction. The conceptual framework and definitions discussed in the following sections will illustrate how these considerations and themes in the literature review guide the methodology of this research.

2.6 Conceptual Framework

Figure 2 depicts the conceptual framework and the linkages between the prominent concepts for this research. The conceptual framework was developed based on the literature review and a combination of two areas of study: professional legitimacy and HHR policy decision-making. The two main theories explaining occupational regulation, Public Choice or Public Interest, are the theoretical foundations for the exploration of the research questions. Culture and hierarchy are the forces that influence each part of the HHR policy process, including the relationship between occupational regulatory status and professional legitimacy.

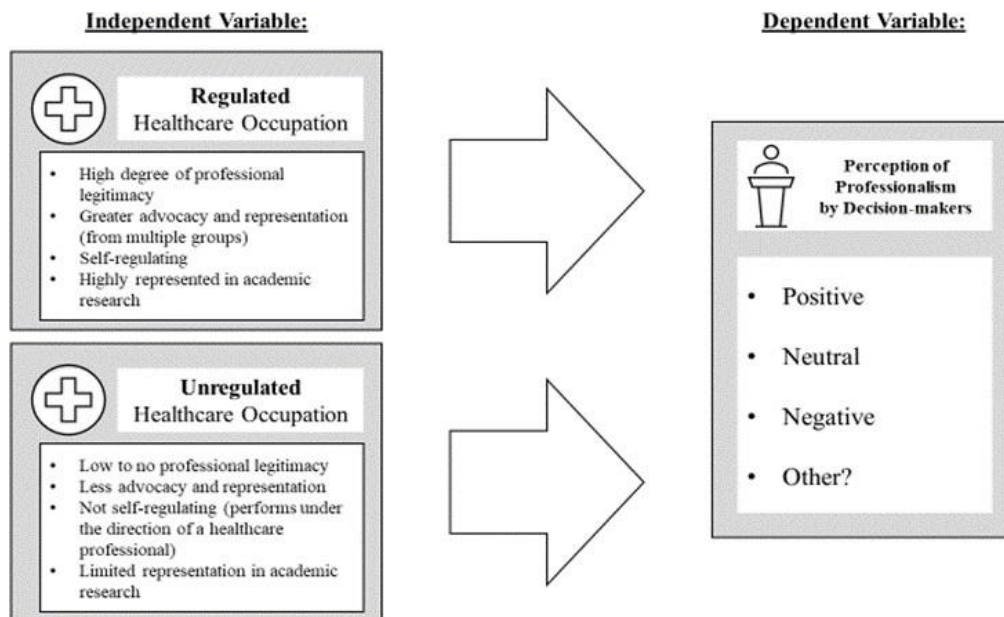
Decision-makers are influenced by professional legitimacy in the decision-making process. Those decisions ultimately determine the policies and outcomes. The conceptual framework has evolved and is revisited in Chapter 5.5 based on the data that emerged.

Figure 2. Conceptual framework



The focus of this research is the specific contribution of the occupational regulatory status to professional legitimacy, and the influence of both on the perceptions of decision-makers. Figure 3 depicts the independent variables, the key differences between regulated and unregulated healthcare occupations, and on the dependent variable perception of professionalism by decision-makers.

Figure 3. Variables of concern



Due to the limitations in the academic literature, this research uses multiple methods to explore the concepts of interest. In the following sections the methods used in this research are discussed, based on the conceptual framework in this chapter. Based on the data secured from the use of these additional methods, the conceptual framework is then revisited and revised in Chapter 5.5.

Chapter 3: Background

While HHR and occupational regulation have massive implications on the delivery and quality of health services, there are various nuances based on the jurisdiction and the influences on HHR. This chapter provides an overview of HHR policy and occupational regulation in Canada and specifically, B.C. More broadly, the roots of professionalism and the effect on healthcare occupations and regulation are presented. An introduction to the sweeping HHR policy changes to unregulated occupations and well as questions in the public sphere regarding professionalism are examined.

3.1 Professionalism & Healthcare Occupations

The origins of professionalism can be traced back to ancient times, when highly skilled individuals organized themselves into guilds to protect and ensure quality of their craft (Marshall, 1939). Over time, these guilds established standards, codes of conduct, and educational requirements to regulate their respective professions. This framework continues to shape how professionals are regulated today. Professionalism as a concept further evolved during the Industrial Revolution when the growth of modern industries led to increased demand for greater specialized skills and knowledge (Applebee, 2006).

Governments began to regulate healthcare occupations in the nineteenth century in response to concerns about the quality of care provided by untrained and unlicensed workers. During this time, there were few standards for healthcare education and training, and many people practiced medicine without any formal education or certification. The lack of education led to inconsistent and risky practices, and there was a growing recognition that the public needed protection from unskilled or unethical practitioners (Applebee, 2006; Encyclopedia.com, n.d.).

Health care was not always seen as a profession, especially in the early days of medicine. Physicians were often seen as ‘tradespeople’ who deliver services rather than knowledge or expertise (Applebee, 2006). With the advancement of medical knowledge and training, the concept of professionalism in health care began to emerge. The creation of medical schools, the adoption of rigorous standards for medical education, establishment of medical codes of ethics, professional standards, and the growth of professional organizations led to the development of healthcare professionalism. The development of professional organizations helped to promote the ideals of professionalism in health care, establish standards for the profession, promote research and education, and advocated for policy changes (MacKenzie, 2007).

The first regulatory bodies for healthcare professions were established by European and North American legislators in the nineteenth century. In the United States, the first medical licensing laws, requiring physicians to meet certain educational and training standards to practice medicine were passed in the 1870s (Encyclopedia.com, n.d). Similar laws were passed for other healthcare occupations, such as nursing and pharmacy in later years (MacKenzie, 2007).

Occupational regulation, particularly within medical licensing laws, has been influenced by racism and has had a significant impact on professional legitimacy. The American Medical Association (AMA) played a role in promoting medical licensing laws but tolerated racial exclusion, creating a racially divided and unequal system of medicine in the American South and border states (Singer, 2020). First Nations people in Canada faced similar barriers in becoming professionals. In the 1890s, First Nations men who earned a university degree were

automatically enfranchised and lost their Indian status without their consent (Lawrence & Daum Shanks, 2015; Elections Canada, n.d.). These historical circumstances highlight the racist elements within occupational regulation and their adverse effects on professional legitimacy, ultimately limiting access to health care and perpetuating inequality.

Currently, most countries have regulatory bodies that oversee the education, training and licensure of healthcare professionals (Applebee, 2006). These regulatory bodies play a crucial role in ensuring the safety and quality of healthcare services. Not all healthcare occupations are regulated and hold a professional designation. There are many advantages to holding the title of health professional as there are greater opportunities to advocate and lobby decision-makers to affect HHR policy, affecting their own occupations and sometimes other healthcare occupations.

During the early years, occupational licensing and regulations were implemented in a public interest framework to improve health outcomes. Licensing aimed to safeguard public health by setting standards and requirements for professionals, addressing information asymmetry, and reducing risks associated with unqualified practitioners (Anderson et al., 2020). It enhanced accountability and protected consumers by ensuring professionals met specific qualifications, fostering trust and preventing fraudulent practices. Regulation also aimed to reduce market failures and promote a reliable marketplace, although considerations of industry capture and barriers to entry required ongoing evaluation. Overall, licensing within this framework contributed to a safer and more effective healthcare system, benefiting public health and well-being (Anderson et al., 2020; Law & Kim, 2005).

3.2 HHR Policy and Occupational Regulation in Canada and B.C.

In Canada, provinces are responsible for determining human resource policy for regulated and unregulated healthcare occupations and have their own legislation guiding the regulation of healthcare occupations (Aldridge, 2008; Leslie et al., 2021). Provinces determine which occupations are regulated, and the regulatory status of some occupations is not consistent across Canada (Afzal et al., 2018; Balthazard, 2015; Lemmens & Ghimire, 2019; Thompson, 2016).

Overall, in Canada, the main approach of occupational regulation is regulating flexible scopes of practice through tasks (Leslie et al., 2021). In the late 1980s to early 2000s, the expansion of New Public Management (NPM) pushed provincial governments to deregulate and loosen the role of public administration and oversight in some healthcare occupations (Timmons, 2011). While there was a movement to deregulate, national accreditation and educational standards remained untouched. Furthermore, provinces set which regulatory models for occupations and continue to do so. It is common throughout the provinces that health professionals have self-regulatory status through the statutory delegation of authorities to ministries of health to establish regulations and to regulatory authorities to govern respective professions (Leslie et al., 2021).

In B.C., the *Health Professions Act* sets the legislative requirements for what healthcare occupations are regulated, how they are regulated (e.g., the regulatory model), and who regulates. Regulatory colleges that create, administer, and monitor policies and regulation of healthcare occupations are legislated in the *Health Professions Act* (Aldridge, 2008). Many healthcare occupations that are lower on the occupational hierarchy (see p. 6) are unregulated and do not fall under the *Health Professions Act*. Most of these unregulated occupations work under the direction of a regulated healthcare professional. These healthcare professionals include allied health (e.g., physiotherapists and occupational therapists), medical staff (e.g., physicians

and surgeons), and nurses (e.g., registered nurses and nurse practitioners). These regulated healthcare professionals are at the top of the hierarchy that occurs in the workplace due to the comprehensive scope of practice that is reserved to them, and the high degree of self regulatory authority that is delegated to them by governments (Franco & Tavares, 2013; Sutherland & Leatherman, 2006). Over the past couple of decades, B.C. has seen significant changes in HHR policy for both regulated and unregulated occupations (*Health Professions Act*, 1996; *Medical Practitioners Regulation*, 2008; *Nurses (Registered) and Nurse Practitioners Regulation*, 2008)

3.3 Sweeping Changes to Unregulated Occupations

In the early 2000s, B.C. ushered in a new government who used NPM as a cornerstone of their strategy and decision-making. This new government direction included a decision in 2001 to contract and privatize the majority of unregulated healthcare occupations, leading to the privatization and layoffs of over 8,000 unregulated healthcare workers. Some of 8,000 laid off workers moved to the private sector, others never were rehired (Banerjee et al., 2021; Stinson et al., 2005). These healthcare occupations relied heavily on representation from labour unions to advocate to decision-makers against these changes to unregulated occupations. Labour unions are one of the only channels for unregulated healthcare occupations to share their ideas and experience from the front lines to shape policy. While these occupations were still performing the same roles as before and at the same worksite, many workers reported that because they were not part of the public health system they were being mistreated and perceived as ‘less professional’ and ‘less of a healthcare worker’ (Banerjee et al., 2021; Kinder, 2020). Although the contracting out of these healthcare services reduced public oversight of their quality, the responsibility for HHR policies of these unregulated healthcare occupations were passed onto health authorities or the worksite (Banerjee et al., 2021; Stinson et al., 2005).

3.4 Questioning Professionalism

Professionalism is under growing scrutiny, especially in the healthcare sector, with many issues that emerge linked to a broad range of behaviours distinct from the professional’s technical ability (Dopelt et al., 2022; Health & Care Professions Council, 2014; Watts, 2008). Regulatory colleges collect and investigate public complaints regarding the professional conduct of its members, as well as enforce any penalties for misconduct. In the mid-2010s, colleges and the professions that they regulate came under public scrutiny in B.C. through a series of high-profile complaints directed at professions such as dentists that questioned the professional conduct of these professionals and the efficacy of the self-regulatory model (Lindsay, 2019c). Healthcare professionals, that faced complaints, have greater representation from a variety of professional associations to advocate on the professions’ behalf and greater professional legitimacy due to their occupational regulatory title. The influence that these regulated health professionals have is a concern for the public and raised more questions regarding whose interests that these regulatory colleges were serving.

In 2018, the Ministry of Health commissioned an external expert to examine and provide recommendations on improvements to the *Health Professions Act* and the overall occupational regulatory system for healthcare professions (Lindsay, 2019b). It was deemed that the *Health Professions Act* was outdated to the point where substantive changes are required for the systemic overhaul of occupational regulation. In 2022, the *Health Occupations and Professions Act* was introduced based on the findings and recommendations of the 2018 examination (Visconti, 2022). As of the drafting of this thesis, the proposed changes to the *Health Professions*

Act have not been enacted and face scrutiny from some health professions (e.g., physicians) while being welcomed by other unregulated health occupations. (DeRosa, 2023; Maxwell, 2023).

3.5 Summary

Professionalism has a long history and was formalized during the Industrial Revolution due to the growth of modern industries and demand for specialized skills and knowledge. Concerns regarding the quality of healthcare services led to government enforcement and creation of regulatory bodies for the oversight of healthcare occupations in the nineteenth century. In Canada, HHR policy and occupational regulation is under provincial jurisdiction. There have been many influences, such as NPM, that have shaped schools of thought regarding the occupational regulation in health care. Sweeping changes to HHR of unregulated occupations occurred in many jurisdictions, including B.C. in the early 2000s. Discussions of professionalism and occupational regulation in health care are relevant today as they were centuries ago.

Chapter 4: Methodology and Methods

In this chapter, the data collection methods used for this study are detailed. Two case studies were explored in this study and mapped relevant themes uncovered in the literature review. Additionally, B.C. HHR decision-makers were interviewed to establish themes addressing the concepts regarding perception of professional legitimacy of healthcare occupations. The study was approved by the University of Victoria Human Research Ethics Board (certificate #22-0748) on January 6, 2023.

4.1 Methodology

This research uses an exploratory mixed-method approach to conduct a phenomenological analysis of the themes found in the study. Creswell (2007) states that a phenomenological study “describes the meaning for several individuals of their lived experiences of a concept of a phenomenon” (p. 57). A phenomenological approach was selected as it allows for the study of an individual’s lived experience (i.e., in this thesis the lived experience of HHR decision-makers) in the world and their perspectives on the research topic, and to relate the experiences to the themes uncovered in the literature review and case studies (Neubauer et al., 2019; Smith, 2018). This approach is most appropriate for the analysis in this study as all information provided by the participants must remain confidential.

An exploratory approach was selected to identify core themes in the literature review of professional legitimacy and occupational regulation, and explore those these in two case studies in B.C. HHR. Exploratory research has the goal of formulating problems more precisely, to gather explanations and insights for future study (Yin, 1994). It was selected also for this study due to its flexibility and the limited prior research on the perception of professional legitimacy of healthcare workers by decision-makers.

The methods selected for this study integrate multiple approaches to extract data using a thorough literature review, case studies, and subject matter expert interviews. Using these methods to explore whether the regulatory status of an occupation has any impact on policy and decision-making, interviews provide insights on decision-making and HHR. The interviews provide insights as to whether any additional factors may affect the perception of non-professional health occupations and any nuances of the policy or decision-making processes.

4.2 Methods

This research uses mixed methods to address the questions. The first method is a literature review of healthcare occupational regulation and the perceived professional legitimacy of healthcare workers, focusing on the non-professional and unregulated occupations (refer to Chapter 2) to retrieve themes used for the analysis. The second method is two case studies directly linked to the themes covered in this study. The third method is interviews of former HHR decision-makers.

Case Studies: This thesis examines two case studies: one on contracting-out healthcare services and the other on repatriating healthcare workers and proposed revisions to the B.C. *Health Professions Act*. These case studies are relevant to this topic because they both generated public discourses about the professionalism of healthcare occupations and professional regulation. Both case studies offer concrete examples within the B.C. HHR sector of some of the strategic decisions of the government that affected thousands of healthcare workers, and current public discourses on health professionals and their motivations to be regulated.

Case Study #1: Bill 29 & 94: Impact on Unregulated Healthcare Workers (p. 26) highlights dramatic changes to the unregulated health sector workforce leading to the privatization and contracting out to multinational corporations to save public funds. Case Study #2: Changes to the *Health Professions Act* (p. 32) highlights significant changes to oversight and regulation of current healthcare professionals through their regulatory colleges and the debates that are occurring today. The two main differences between the two case studies are the regulatory status of these healthcare workers and the framing of the government’s direction for the public’s best interest. In Case Study #1, the changes to unregulated healthcare workers were done to save taxpayers’ dollars; in Case Study #2, changes to regulated healthcare care occupations to improve quality and access to healthcare services.

Due to the limited academic sources on the topics covered in this research, the case studies rely on legislative sources (i.e., legislation and bills) found through the B.C. Government Law Publication Website (www.bclaws.gov.bc.ca) and news articles, press releases and statements from relevant organizations (e.g., regulatory colleges, professional associations, and labour unions).

Decision-Maker Interviews: Semi-structured interviews are used to identify gaps in the data or other areas for consideration. This method allows for collecting rich qualitative information from former health sector decision-makers. Seven experts were interviewed. Appendix B is the invitation email for participants, and Appendix C is a copy of the consent form for participants. Participants are anonymized in the reporting to protect the integrity of the results. *Table 2* outlines the various groups in the B.C. healthcare context that are represented by participants. Appendix D includes the interview guide and questions.

Table 2: Interview Cohorts

Decision Makers	Advocates
B.C. Ministry of Health (e.g., Minister, Deputy Minister, Associate Deputy Ministers, Executive Directors)	Labour Unions/Bargaining Associations (e.g., B.C. Nurses Union (BCNU), B.C. Federation of Labour)
Professional Colleges (e.g., B.C. College of Nurses and Midwives)	Professional Associations (e.g., Nurses and Nurse Practitioners of B.C.)
Health Authority*	Academia (e.g., HHR and labour studies)

*Participants may have current affiliation with a health authority; however, participants were not asked questions about their current roles.

These cohorts were selected for this research due to the breadth of their perspectives and experiences. They provide a robust understanding of influences on decision-making in HHR policy. Sixteen former high-ranking decision-makers in the B.C. HHR sector received invitations. Of the sixteen invitations, eight responded and seven were interviewed. While further details of the background of each participant cannot be disclosed due to the high probability of identifying these individuals, collectively, this participant pool provides perspectives from different governing political parties, academia, health authority, strategic and operational HHR policy, labour unions, and front-line health professionals.

Privacy and confidentiality of all participants were considered and shaped the reasoning behind the selection of tools and formats for this portion of the study. Interviews were audio recorded only with the participant’s consent, and all data extracted from the meetings were removed from all personal identifiers aside from organization affiliation and role. Participants

were identified through a search of public directories and selected through their affiliation with the various organizations outlined in Table 2. The primary investigator contacted them to determine interest in participating in this research. Participants' contact information was collected through publicly accessible online searches (i.e., Google and LinkedIn).

4.3 Data Analysis

An exploratory and phenomenological approach to examining case studies and performing semi-structured interviews provided the necessary evidence to answer the research questions (p. 37). The two case studies were selected because they occurred within the past 20 years in B.C. and directly pertain to significant changes to HHR policy and occupational regulation. Microsoft Excel was used to document and group keywords and ideas from pieces of evidence relevant to each case. Themes were grouped and reviewed to source general themes of the case study. Each case study's theme was reviewed and compared with the themes sourced from the literature review.

To analyze the data collected during the interviews, Microsoft Excel was used to group key phrases and ideas into themes. Interview recordings were reviewed and transcribed. Each of the seven interviews was reviewed for any additional themes that emerged in the specific interview. Interview themes for individual participants were compared with each other to seek universal themes. Finally, the themes were compared with the other themes that were revealed in the case studies and literature review.

4.4 Strengths and Limitations

Limitations: The limitations of this study include limited access to current and former decision-makers due to privacy concerns and a lack of access to their contact information. Future studies should consider including health authority staff, board members, and decision-makers and obtaining additional ethics approvals. The study also relies heavily on the conceptual framework based on theories due to the limited research on unregulated health occupations in the literature. However, the use of multiple theories helps address the gaps in the literature.

Strengths: This study brings attention to a population that is not well represented in the literature, and aims to add to the literature of unregulated healthcare occupations. Furthermore, the use of a mixed-method approach and phenomenological analysis gathers rich evidence to link with existing themes in the academic literature. The study also provides important insights into the linkages between professional regulatory status and perceptions affecting HHR decision-making, offering a basis for further research and context-appropriate recommendations.

Chapter 5: Findings

The findings from the two case studies and interviews with decision-makers are outlined below in the corresponding themes that emerged. The main themes identified in all three methods are occupational regulation, culture and hierarchy, government and decision-making, and professional legitimacy.

In the following sections, the main themes are discussed, along with any of the subthemes that have emerged in the findings. For the two case studies, the cases are written chronologically as the events occurred, with the themes discussed throughout the case studies.

5.1 Case Study #1 – Bills 29 & 94: Impact on Unregulated Healthcare Workers

Bill 29 – 2002: Health and Social Services Delivery Improvement Act and *Bill 94 – 2003: Health Sector Partnerships Agreement Act* were selected as a case study for this research to highlight the challenges that unregulated nonprofessional healthcare workers faced because of government decisions affecting provincial HHR policy. These unregulated healthcare workers are usually represented by labour unions and have little direct representation in policy and decision-making forums. The unions involved were successful in taking the government to the Supreme Court of Canada. From this case, it is evident that decision-makers would not have made changes to these laws without the influence of labour unions. Overall, this case, *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia, 2007 SCC 27* (“*Health Services case*”) also marked a significant change in the jurisprudence shaping labour and HHR laws in Canada. This case study reflects a dramatic shift in policy changes that occurred as a result of a change of government, framing of decisions in the public interest, and change of perception of the type of care that these healthcare workers provide. This case was also selected to examine a few themes found in the literature review regarding the public interest in occupational regulation, culture and hierarchy, attention to certain occupations, government and decision-making, and reliance on professional legitimacy. Other emergent themes covered in the case study are influence of unions and associations, leadership, legislation, and recognition of health support workers.

Government & Decision-Making

NPM became the driving paradigm of many governments since the 1980s, including the U.K., U.S., and many provinces in Canada including B.C. in the early 2000s (Abbott, 2020; Banerjee et al., 2021; Elkomy, et al., 2019). B.C. Liberal Premier Gordon Campbell (2001–2011) successfully campaigned on many promises to usher in a New Era to “cut red tape” and reduce government costs (Abbott, 2020). However, one of the core promises made to not reduce the number of public sector contracts and employees, especially in health care, was broken.

Legislation: Building on the New Era and reduction of government costs, the Ministry of Skills Development and Labour introduced two major legislative acts in the early 2000s. The first was Bill 29, the *Health and Social Services Delivery Improvement Act*, and the second in 2003 was Bill 94, the *Health Sector Partnerships Agreement Act*. Both acts led to swift changes in HHR and other labour sectors (Press Progress, 2019). While the Bills were repealed in 2019, Bills 29 and 94 had widespread effects on the lives of thousands of workers, patient care, and HHR policies (Sandborn, 2009; Sandborn, 2007a; Stinson et al., 2005). The rationale of Bill 29 was to

...enable health employers and social service agencies to deliver cost-effective and improved services to the public by facilitating implementation of new health authorities and social service restructuring, permitting more flexible work arrangements, removing excessive layoff and bumping provisions, and; enabling improved service delivery through open tendering. (Bill 29, 2002, Explanatory Note)

While the first few rationales are out of scope for this study, removing excessive layoff and bumping provisions and enabling improved service delivery through open tendering is of interest.

Public Choice & Public Interest

Many perceptions and justifications for Bill 29 provided further reason for the new government to question whether these contracts were made in the public interest. One key advisor from the Fraser Institute¹ supported the claim that these non-clinical unionized healthcare workers were “providing the same services in private sector hotels and were paid much less than unionized hospital workers” (Sandborn, 2007a, p. 1). These arguments illustrate the perceptions held by strategists, decision-makers, and the public of these workers at the time. These arguments could also lead to the perspective that these healthcare workers did not require the same protections as other healthcare staff, specifically those who were not part of a regulated occupation or a healthcare professional.

While the intention was to remove excessive layoff provisions within collective agreements and terms of employment in the healthcare sector with these changes, bumping was significantly reduced due to the elimination of union representation of many staff; Bills 29 and 94 led to one of the largest mass layoffs in Canadian labour history (Lee & Cohen, 2005; Stinson et al., 2005). An estimated 8,000 people were laid off from their healthcare positions, with women and visible persons of colour overrepresented the layoffs (Lee & Cohen, 2005; Sandborn, 2007b; Stinson et al., 2005). More than one out of four Hospital Employees’ Union (HEU) members belong to a visible minority, compared to less than one in five in the general population (Sandborn, 2007a).

The second intention of interest was to enable improved service delivery through open tendering, commonly referred to as contracting out. While contracting out was a new approach in B.C., contracting out in the healthcare sector was a standard practice in many countries such as the U.S., Finland, U.K., Netherlands, New Zealand, Sweden, and other provinces in Canada (Vining & Globerman, 1999; Vrangbæk et al., 2015). For example, the largest hospital in Canada, Toronto General Hospital, began contracting out a broad range of services, including nutrition services, housekeeping, plant operations and maintenance, transportation, materials management and logistics and laboratory services (Vinning & Globerman, 1999). The practice of contracting out aligns closely with NPM practices as it allows for operations to be subcontracted out of direct public control while shifting the role of public administrators towards the public management of contracts, with the belief that it will lower costs and increase quality (Abbott, 2020; Brown & Potoski, 2003; Elkomy et al., 2019; Goodair & Reeves, 2022).

¹ Fraser Institute is a libertarian-conservative Canadian public policy think tank and registered charity. In B.C., the Fraser Institute’s ideology shares similar ideologies to those of is similar to that of the B.C. Liberal Party (now BC United Party).

In relation to the two theories of Public Choice and Public Interest, the government of the day argued that these decisions were made in the interests of the public to reduce the financial costs of the HHR workforce on the taxpayer and improve service quality. However, in this case study there are many examples where politics and influence were instrumental in the decision-making, and decision-makers assuming what they electorate wanted due to election results. Reducing government spending in this era was a key priority and seen in the public's best interest by political decision-makers.

Professional Legitimacy

Bill 29 also included defining 'designated health services professional' as "(a) a nurse licensed under the *Nurses (Registered) Act*, (b) a person who is a member of a health profession designated under the *Health Professions Act* on the date on which this section comes into force, or (c) a person in an occupation or job classification designated by regulation" (Bill 29, 2002, s. 6.1). Under these definitions, many healthcare workers who were unregulated were exposed to significant changes to their occupations by their employers with little legislative or regulatory protection. Those that were defined as a "designated health services professional" had their professional legitimacy enhanced and further entrenched in the perception of the provincial laws. The definition of designated health services professional effectively protected regulated healthcare workers from the effects felt by unregulated occupations.

Culture & Hierarchy

Bill 94 was the second piece of legislation that built on the rationale and definitions of Bill 29. Bill 94 was to "facilitate development and implementation of public-private partnerships in the health sector, enabling improved delivery of cost effective non-clinical services to the public" (Bill 94 – *Health Sector Partnership Agreement Act*, 2003, Explanatory Note). The bill used the same definition of non-clinical services as set out in Bill 29, including sections that further exclude unregulated healthcare workers, by stating

The labour relations board or an arbitrator appointed under the Code or under a collective agreement must not declare a person who

- (a) provides non-clinical services at or for a designated health care facility under a contract between a designated private sector partner and another person, and
- (b) is an employee of the other person

to be an employee of the designated private sector partner, or of a health sector partner, unless the designated private sector partner or the health sector partner intended the employee to be fully integrated with the operations of the designated private sector partner or the health sector partner, as the case may be, and intended the employee to be working under its direct supervision and control. (Bill 94, 2003, s. 4.2)

Effectively, Bills 29 and 94 permitted public health sector employers the right to contract out non-clinical services (i.e., housekeeping services; residential health care aides; facilities, janitorial, maintenance and laundry services staff; food service workers; security staff; and information technology and accounting staff), removing all collective agreement restrictions on contracting out for non-clinical services (Lee & Cohen, 2005; Ministry of Health, 2018; Stinson, Pollak et al., 2005). All non-clinical services are health services except for medical, diagnostic, or therapeutic services provided by health professionals, as defined in the *Health Professions Act*. Savings resulting from the Bills were projected at \$415 million starting in the fiscal year 2004/05, allowing those resources to be refocused on core patient services (Sandborn, 2009).

Both bills also denied healthcare workers fundamental rights available to all other workers in the province under sections 35 and 38 of the B.C. *Labour Code* (Ministry of Health, 2018). These contracted-out healthcare workers had fewer opportunities to unionize, be represented by unions in collective bargaining and stay unionized as companies could give up contracts and rehire staff under a new contract for entry-level wages, despite working the same role (Lee & Cohen, 2005; Stinson et al., 2005; Vescera, 2022).

Attention to Certain Occupations: The individual effects on workers and their families were devastating, with wages reduced by 50%, public sector pensions lost, and job security becoming precarious. The stories of the personal effects of Bills 29 and 94 are plenty and demonstrate the direct impact of strategic policy direction on the lives of thousands of individuals (Lee & Cohen, 2005; Stinson et al., 2005). While various labour groups attempted to draw attention to the situation, the public consensus was that contracting-out was in the best interest of all British Columbians to reduce public spending and reallocate cost-savings (Sandborn, 2007b). The official government opposition was reduced to two MLAs during the 2001 election leaving minimal political opposition (Sandborn, 2007a).²

Influence of Unions and Associations

While the might of the labour representation was significantly weakened and there was minimal concern from the public, the efforts to represent these healthcare workers continued and unions looked to appeal to higher authorities. In 2003, several complaints were submitted by unions against the government to the International Labour Organization (ILO) in the United Nations for claims that the Bills went against international labour standards and infringed on the rights for collective bargaining (ILO, 2005).³ The various unions affected and individual workers who were directly affected took the government to the Supreme Court of Canada ("*Health Services Case*" SCC) over Bill 29, claiming that the bill violated workers' protections under the *Charter of Rights and Freedoms*.⁴ In both cases, the ILO and SCC ruled in favour of the unions and found that the provincial government was in violation.

In the SCC case, sections of Bill 29 were ruled unconstitutional. Specifically, the Court held that provisions in sections 6 and 9 significantly interfered with the right to collective bargaining and violated section 2(d) of the *Canadian Charter of Rights and Freedoms* (Ministry of Health, 2018; *Health Services Case*). Excerpts of the ruling are presented below.

The section 2(d) infringement is not justified under s. 1 of the Charter. While the government established that the Act's main objective of improving the delivery of health care services and sub objectives were pressing and substantial, and while it could logically and reasonably be concluded that there was a rational connection between the means adopted by the Act and the objectives, it was not shown that the Act minimally impaired the employees' s. 2(d) right of collective bargaining. The record discloses no consideration by the government of whether it could reach its goal by less intrusive measures. A range of options were on the table, but the government presented no evidence as to why this particular solution was chosen and why there was no meaningful consultation with the unions about the range of options open to it. This was an important and significant piece of labour legislation which had the potential to affect the rights of employees dramatically and unusually. Yet, it was adopted rapidly with full knowledge that the unions were

² Member of the Legislative Assembly (MLA)

³ Cases Nos. 2166, 2173, 2180 and 2196.

⁴ *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia*

strongly opposed to many of the provisions, and without consideration of alternative ways to achieve the government objective, and without explanation of the government's choices. (SSC, 2007, p. 16)

In this case, the freedom of association of health care employees has been infringed in several instances, because ss. 4, 5, 6(2), 6(4) and 9 of the Act (in conjunction with s. 10) interfere with their right to a process of collective bargaining with the employer. Sections 4 and 5 nullify some existing terms of collective agreements, limit the scope of future negotiations and prevent workers from engaging in associational activities relating to the important matter of transfer and assignment of employees. Sections 6(2) and 6(4) nullify past collective bargaining relating to contracting out, thereby rendering the process nugatory, and preclude future collective bargaining on the issue. These provisions concern a significant issue of employment security, and negotiating such issues is one of the purposes of associational activities in the workplace. Lastly, s. 9 makes collective bargaining over specified aspects of layoff and bumping meaningless and invalidates parts of collective agreements dealing with these significant workplace issues. (SSC, 2007, p. 20)

We conclude that the s. 2(d) guarantee of freedom of association protects the capacity of members of labour unions to engage in collective bargaining on workplace issues. While some of the impugned provisions of the Act comply with this guarantee, ss. 6(2), 6(4) and 9 breach it and have not been shown to be justified under s. 1 of the Charter. We further conclude that the Act does not violate the right to equal treatment under s. 15 of the Charter. In the result, the appeal is allowed in part. (*Health Services Case*, 2007, p. 43)

For many Charter watchers, the ruling was shocking as it was path-breaking and went against a previous line of decisions known as the Labour Trilogy jurisprudence. The Labour Trilogy is a series of precedents that shaped Canadian labour law between 1987 and 2007 that held that freedom of association did not encompass constitutional protection of a right to collective bargaining or a right to strike (Neuman, 2016, p. 16). A result of the ruling from the 2007 case from B.C. led to the next series of cases that set a new trilogy of precedents to allow “for associations of individuals in the labour relations sphere of activity to have access to a meaningful process of collective bargaining to pursue their workplace aspirations” (Neuman, 2016, p. 18). While this thesis is not an examination of the laws, this information provides insights as to what the legal precedents were in the day that shaped legislation. For example, the insights of the legal precedents inform the parameters that government and decision-makers were operating within and what they believed to be justifiable decisions under Canadian law.

In 2008, specific provisions in both Bills 29 and 94 were repealed after the government was permitted one year to negotiate a settlement aligned with the court's decision (Ministry of Health, 2018). However, the long-lasting impacts of both Bills were felt by individuals, workplaces, and throughout the labour sector. Other provisions of the statutes remained in force, including those denying workers transfer of bargaining rights through successorship and standard employer protections (section 6 of Bill 29 and section 5 of Bill 94). Throughout the years after the 2007 SSC ruling, contract flipping still occurred. Reports emerged that other healthcare staff like HCAs and LPNs were facing layoffs, increasing the initial 8,000 layoff number over the years (Sandborn, 2007b). This era also resulted in the significant expansion of administrative and management resources required to oversee the growth of privately contracted healthcare services (Sandborn, 2007b).

Leadership

A catalyst for change and the eventual repeal of Bills 29 and 94 came after the 2017 election and the change of the ruling party. The B.C. New Democratic Party (BCNDP) formed government in 2017 under Premier John Horgan, who campaigned on the promises to repatriate contracted-out healthcare workers and reinvest to bring more health services back into the public system. The official announcement of Bill 47 - *Health Sector Statutes Repeal Act* was made on November 8, 2018, by Minister of Health Adrian Dix at the HEU biannual convention in front of hundreds of healthcare workers, many of whom were directly affected by Bills 29 and 94 in the early 2000s (Ministry of Health, 2018; Thomas, 2018).

Bill 47 was enacted through regulation on July 1, 2019, and both Bills 29 and 94 were repealed. This opened the doors to the repatriation of approximately 4,000 housekeeping and food service workers (i.e., cooks, dietary aides) within public healthcare facilities in B.C. (Ministry of Health, 2021). Bill 47 intends to promote a stable and effective workforce by positioning these roles as attractive job options for workers entering the HHR sector (Bill 47, 2019). The government collaborated with labour unions, health authorities, and contractors for this change (Ministry of Health, 2021). Most housekeeping and food service workers were repatriated in 2022, marking the end of nearly two decades of precarious labour conditions.

Leadership is a theme of importance in this case study and the research overall because it was the greatest catalyst and factor that led to the significant changes in B.C. HHR policy. It also signalled a change in the government's perspective in what was in the best interests of the public, which was that all healthcare workers were public sector employees and that government required a greater role in the strategic and operational HHR strategies.

Recognition of Health Support Workers

One of the key arguments supporting Bill 47 presented by the new government was that “people in acute care facilities will have more consistent, safe and stable patient care” due to the repatriation of health services (Ministry of Health, 2021, p.1). Over the years, the literature has been expanding, offering policy and program evaluations comparing various outcomes between public and contracted-out facilities. Recent literature supports the idea that services that are kept within the public sector leads to more positive outcomes (Banerjee et al., 2021; Goodair & Reeves, 2022; Grimshaw & Carroll, 2006; Longhurst, 2017; Messing, 1998). Several studies of the U.K. healthcare system support this finding, with one study finding that while privatization of the National Health Service in England had been occurring for decades, “private sector outsourcing corresponded with significantly increased rates of treatable mortality, potentially because of a decline in the quality of healthcare services” (Goodair & Reeves, 2022). A review of the literature by Banerjee et al. (2021) found that poorer working conditions and poorer quality of health services delivered in long-term care facilities were delivered by private companies.

In 2020, the B.C. Office of the Seniors' Advocate (OSA) also made similar observations and found that staff do the same work for less and pocketing the savings is precisely what for-profit operators are expected to do. However, the OSA questioned “whether direct care hours in publicly funded long-term care homes is where we want operators to find efficiency” (OSA, 2020, p. 28). The dire impacts of contracting out these services were acutely demonstrated during the COVID-19 pandemic, where fewer pandemic and occupation health and safety

precautions were implemented at private facilities. More significant outbreaks and higher patient mortality rates were also seen in privately contracted sites (OSA, 2020).

Summary

Over the decades, lessons have been learned to regard to the negative effects of privatization and contracting out, specifically in health care, and strides have been made to reverse previous decisions that were made; however, the impact of privatization is widespread, and it will take years for systemic improvements. Unregulated healthcare workers and their concerns in this case were perceived as not as legitimate as those of their regulated colleagues, who were not as affected by Bills 29 and 94. This case also highlights unregulated healthcare workers and their reliance on labour unions to influence decision-makers and leadership and the politics of the day. Furthermore, this case shows the significant impact of politics of the day and the recognition of healthcare workers on provincial HHR policy and decision-making; shifts in both themes led to heightened interest in unregulated healthcare workers and the role they have in the delivery of health care.

The limited academic literature on the HHR policy pertaining to and working conditions of health care support workers has not contributed to the advocacy efforts on behalf of these unregulated occupations. With more studies by authors like Banerjee et al. (2021), and others, there are indications that there is increasing attention paid to the critical role of these workers.

5.2 Case Study #2 – Changes to the Health Professions Act

Bill 36, the Health Professions and Occupations Act is the proposed legislation intended to replace the current act regulating health professionals in B.C. This situation was selected as a case study for this research to examine the themes and discourse pertaining to the professional occupational regulation of healthcare professionals, as well as the effects on healthcare professionals. The proposed changes to occupational regulation in B.C. are due to decision-makers' responses to a series of problematic instances where some regulatory colleges and professional associations were not acting in the best interests of patients. Significant changes to the Act are being proposed, and some current health professionals are not satisfied with the proposals. Other health occupations that are seeking to be professionally regulated and increase the perception of their occupation's professional legitimacy are looking forward to the changes. This case was also selected to examine themes found in the literature review including the purpose of occupational regulation; Public Choice or Public Interest; occupation's interests in regulation; difference between regulatory regimes, government and decision-making; influence of unions and associations; as well as the reliance on professional legitimacy in decision-making. Other themes covered in the case study are legislation, and consultation and collaboration.

Government & Decision-Making

Increased attention to regulation and the role of professional colleges in the healthcare sector came to prominence in the spring of 2018, when a series of complaints against various professional health regulators prompted the B.C. Ministry of Health to evaluate the province's regulatory regime. In response, the Ministry commissioned Harry Cayton, a regulatory expert and former chief executive of the U.K.'s Professional Standards Authority, to provide recommendations for the modernization of the regulatory framework and improvements to public protections. The *Health Professions Act* was enacted in 1979 to shape health professional regulation in B.C. Despite multiple past attempts to modernize the Act since its inception, Cayton stated, "quite simply the *Health Professions Act* is no longer adequate for modern

regulation,” and that it would require “significant changes to meet future requirements for protecting the public” (Cayton, 2018, p. 70).

Reliance on Professional Legitimacy

Cayton found that the colleges’ controversies and lack of transparency had led to the “eroded public trust in the province’s professional regulatory bodies” (Visconti, 2022). Cayton spent months with one college under the most scrutiny, the College of Dental Surgeons of B.C. (CDSBC). Cayton’s examination of the CDSBC used multiple sources, including over 40 interviews with current and former Board members and staff, correspondence with the public and patients, an audit of 30 complaint files, and correspondence concerning the CDSBC business and meetings. This thorough review allowed Cayton to use this specific college as a case study. It led to a scathing report that found the main issues with the regulatory colleges were governance, performance, and external relationships. These issues occurred over a long period and might have been able to persist because of the perception of professional legitimacy of these health professionals. While Cayton acknowledges that not all the colleges were problematic, the report’s thesis is that the *Health Professions Act* is the foundation that led to systemic and pervasive issues in the professional colleges and practice of individuals (Cayton, 2018).

Another concern that Cayton highlighted was the relationship between the CDSBC and the professional association representing the interests of dentists, the British Columbia Dental Association, being too close. He found that that the CDSBC collected registration fees that fund the association and cited instances when the CDSBC’s decision-making process was significantly influenced by the association. This finding led to questions regarding the effectiveness of the CDSBC as an independent regulator of dentists when “it is physically, financially, and humanly intertwined” with the association (Cayton, 2018, p. 50).

Cayton’s work resulted with a scathing report on the controversies and lack of transparency in regulatory colleges that led to an erosion of public trust in professional healthcare occupations. The report identified issues with governance, performance, and external relationships among regulatory colleges. Cayton’s report also highlighted concerns regarding the physical, financial, and human intertwinement between the CDSBC and the British Columbia Dental Association. The findings raise questions about the professional legitimacy of healthcare occupations and the effectiveness of regulatory bodies in the public’s best interests.

Public Choice or Public Interest

Cayton also noted that “there is a lack of relentless focus on the safety of patients in many but not all the current colleges. Their governance is insufficiently independent, lacking a competency framework, a way of managing skill mix or clear accountability to the public they serve” (Cayton, 2018, p. 72). Cayton later states, “...patients I have spoken to do not have great confidence in the colleges or in health regulation generally” (Cayton, 2018, p. 72). As Cayton describes, those patients perceive the current system as being built around secrecy, with only a few complaint outcomes ever being publicized (Cayton, 2018; Lindsay, 2019b). Concerns are explicitly raised on informed patient consent to care if they cannot access information regarding if their health practitioner has had a complaint upheld against them.

Cayton produced two sets of recommendations: first, to recommend the reform of the *Health Care Professions Act* and second, to establish a new provincial regulatory system for occupations. Legislation is required to enable and give effect to Cayton’s findings and recommendations. There are several recommendations to reform the Act:

- Update the Act’s mandate to: ‘It is the duty of a college at all times; To protect the safety of patients, to prevent harm and promote the health and well-being of the public;
- Move to fully appointed boards combining health professionals and members of the public in equal parts (including transparent appointment processes, reduction of the membership size of Boards, and Boards removed from any involvement in complaints and discipline);
- Separate colleges entirely from professional associations;
- Actively encourage and facilitate mergers to reduce the number of colleges;
- Place a moratorium on creating any new colleges;
- Revise the complaints process to make it more efficient, transparent, and fair;
- Improve the reporting of data;
- Change the role of the Health Professions Review Board (HPRB) to help colleges improve response to complaints. (Cayton, 2018)

However, with all the discussion regarding regulation, Cayton introduced a ‘risk-assessed model’ for the oversight body to determine which professions should be regulated (Cayton, 2018). This proposed model differs from the current approach. Currently, professional associations seeking regulation and professional designation under the Act must apply to the minister, who may refuse the application without investigation or conduct any sort of investigation the minister considers necessary to determine whether the health profession should be regulated (*Health Professions Act*, s. 7). The new model would be based on the potential harm to patients based on the level of risk the occupation’s activities have on public health, considering the likelihood and severity of harm (Cayton, 2018; Durcan, 2019; Lindsay, 2019a; Ministry of Health, 2020). Using the model, a new oversight body would recommend to the minister which unregulated occupation should be regulated, and the minister’s final decision would go to cabinet for a final decision (Ministry of Health, 2020, p. 14). The oversight body would also recommend how to address the risk of harm by the occupation and review currently regulated health professions. This review could result in some colleges potentially being eliminated. As Cayton puts it, the current system can be summed as “whatever profession has lobbied hard enough...has managed to win itself a college” (Lindsay, 2019c, p. 1). Whatever profession had the resources to lobby could become regulated and further the occupation’s interests.

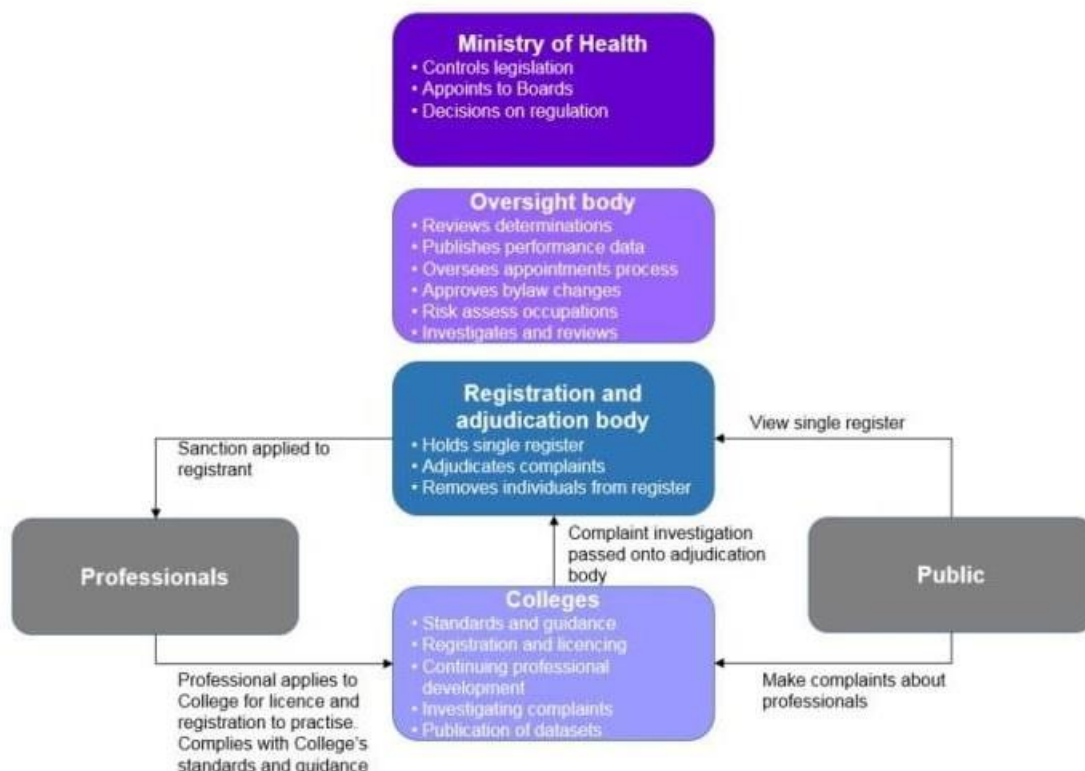
Legislative Processes & Constraints

Cayton recognized significant limitations to working within the current regulatory framework and advocated replacing the *Health Professions Act* entirely. This recommendation was proposed because problems persisted even with significant leadership shifts in some colleges. “New legislation will be necessary to achieve structural reform [since the Act] will not be sufficient to create a regulatory framework fit for the future of health care” (Cayton, 2018, p. 85). The recommendations for the new regulatory system included the following:

- Create a single code of ethics and conduct for all health professions;
- Permit Colleges to investigate complaints but not adjudicate them;
- Establish a single register and adjudication body for all health professionals;
- Create a new oversight body for health professional regulation in B.C. that absorbs the functions of the HPRB and;
- Introduce a risk-assessed model to determine who should be regulated.

Figure 4 depicts the proposed new structure for health professional regulation in B.C., with the various partners involved in professional regulation, including the public and professionals. Colleges would still play a vital role, but their new focus would be to set standards of practice and license professionals. All colleges would agree to a single code of ethics and conduct. Just below the Ministry of Health would sit a new oversight body, replacing the HPRB with additional powers, including the risk assessed model to determine patient harms and which occupations should be regulated.

Figure 4. Proposed framework from Cayton’s Report (Cayton, 2018; Lindsay, 2019b)



As previously mentioned, legislation is required to give effect to any proposed changes and shape how occupations are regulated. Legislation is a critical HHR reform tool, as it determines the procedures in which occupations are regulated and what occupations are regulated. Furthermore, legislation may create changes to the overall culture and hierarchy of healthcare occupations as it sets what is permitted for an occupation can do and whether they are professionally regulated.

Consultation & Collaboration

In response to the report, the Minister of Health established the Steering Committee on Modernization of Health Professional Regulation to recommend how the *Health Professions Act* should be regulated. The committee was nonpartisan in that the proposals were created with the support of and in collaboration with government and opposition parties. In August 2020, the committee released a report following an extensive public engagement that included more specific recommendations, including reduce the number of colleges from twenty to six; improve college governance through changes to the composition, size, and appointment process of boards; create a new oversight body; update the complaints and adjudication process; and

improve the sharing of information between colleges (Lindsay, 2020; Ministry of Health, 2020). The recommendations did not suggest the complete deregulation of health professions.

Building on the Cayton Report and Steering Committee's work on reforming the *Health Professions Act*, the Minister of Health used this moment as an opportunity to be "the model for all of Canada for Health Professional Regulation" (Visconti, 2022, p. 1). Other provinces in Canada are observing the outcome of the occupational regulation changes in B.C. for their own regulatory regimes, since similar challenges have been observed in other jurisdictions. In the fall of 2022, Bill 36 - *Health Professions and Occupations Act* was introduced by the Minister of Health. One of the most substantial and detailed bills in B.C. Legislative Assembly history, it comprises 12 sections and 278 pages.

In this instance, creation of a dedicated steering committee was a tactic to increase the consultation and collaboration on the modernization of health professional regulation. The committee was mandated to be a nonpartisan group and collaborated with other groups. Occupations were consulted on the changes and engaged with to inform decisions affecting their occupations. This level of engagement legitimizes the role of these occupations, as they were seen by the committee as important partners to inform the direction of the modernization of the *Health Professions Act*.

Purpose of Occupational Regulation

Bill 36 has two key objectives: to prioritize the protection of the public and promote good governance within regulatory bodies. The expansion of health service provider regulation is aimed at enabling more flexible regulatory models for lower-risk health occupations. Additionally, the Bill aims to facilitate the process for designating new health professions and occupations, establishing an Office of the Superintendent of Health Profession and Occupation Oversight and an independent discipline tribunal (*Health Professions and Occupations Act*, 2022). The *Health Professions and Occupations Act* of 2022 will introduce significant changes from the previous *Health Professions Act*. These changes include embedding requirements for cultural safety and humility, improving the regulatory process, simplifying credential recognition for foreign healthcare professionals, and promoting transparency (*Health Professions and Occupations Act*, 2022). Overall, Bill 36 will affect the entire provincial health system and its 130,000 healthcare professionals in 25 different professions.

Bill 36 is a sign of a major shift in how health occupations are regulated in B.C. The key objectives explicitly identify that protection of the public is prioritized, and that good governance is promoted within regulatory bodies. It is too early to determine if the objectives of Bill 36 are effective; however, this shift identifies that the purpose of government regulating health occupations in this way is to maximize the public's interests.

Influence of Unions and Associations

While Bill 36 has yet to be enacted, it has sparked many dissenting opinions from the opposition parties, colleges, and health professionals. Despite the previous consultations done in the all-party commission and the original Cayton report, many critics have concerns regarding the scope, lack of consultation, and the speed of the bill moving through the Legislative Assembly (Daflos, 2022; DeRosa, 2023; Maxwell, 2023). Presidents of the Doctors of B.C. (DoBC) and B.C. Nurses' Union (BCNU) have spoken out over the lack of thorough consultation with their members, especially during a time when health professionals are burned

out due to high workloads and fatigue from the COVID-19 pandemic and are currently being consulted on other matters (DoBC, 2019). Other health professionals have voiced concerns that it gives the government too much authority over professions through the appointment of college board members (previously elected by the College membership) and concerns over too much transparency of complaints and potential damage to a professional's reputation from the publication of frivolous grievances (DeRosa, 2023). Some other healthcare professionals do not see the system as being broken and requiring the large scope of changes (Daflos, 2022).

Interests of Occupational Regulation

Not all healthcare occupations are opposed to Bill 36; specifically those who have sought professional regulatory status previously support it. Under Bill 36, clinical counsellors will be regulated for the first time in B.C., where other provinces such as P.E.I., New Brunswick, Quebec, and Ontario have been regulating clinical counsellors and psychotherapists for years (Daflos, 2022). Such changes open the door for other occupations to be regulated and the possibility for other services, such as mental health, to be covered under the provincial public health system.

Summary

If Bill 36 passes, no timelines for implementation have been announced; however, due to the enormous scope, it will take years for full implementation. This specific case study is still developing and time will show the full effects on the health system. However, examining the challenges and opportunities of professional regulation in the healthcare system has been insightful for the analysis of this thesis. We see how fundamental legislation is for the occupational regulation of healthcare workers and establishing professional legitimacy of healthcare professions. The case study is an example of the challenges of occupational regulation, attempts to balance the concerns of healthcare occupations, and recognition of the professional privileges that come from self-regulation. However, Bill 36 is an example where the government has stepped in to change regulations in the public's interest and potentially against the interests of some health professionals at the top of the hierarchy, like physicians. Finally, unregulated healthcare occupations might have a chance to become regulated and increase the perception of their professional legitimacy through the introduction of the risk-based assessment. The new risk-based assessment intends to balance the analysis of which occupation should be regulated against the strong lobbying efforts of some associations. In the next section, we will further explore the influence of these associations.

5.3 Interviews with Decision-makers

Seven subject matter experts were interviewed for this study. Among the seven participants, there were a variety of perspectives from different tiers of decision-making, from the political, labour, clinical, patient, and administrative perspectives. The participants' answers have been divided into themes to protect anonymity and confidentiality. All quotes are paraphrases from the experiences shared by the participant. Many of the themes discussed in previous sections emerged in the interviews. For the full list refer to Appendix A. In addition to the themes already identified, the interviews disclosed two other emergent themes - terminology of professionalism and politics.

Power of a Single Profession

All seven interviewees identified that groups representing regulated medical staff (i.e., physicians, specialists, and surgeons) had the most influence on all HHR policies and decision-

making. Physicians dominated policy conversations and consultations to a degree where one participant noted that “the DoBC is the single most powerful union in the province that is not bound by the B.C. Labour Code”. The participants tried to list other groups that were also influential, such as the BCNU, due to their large membership, ability to organize, and impactful communications campaigns. However, the BCNU influence is nowhere close to the force of DoBC. Following the BCNU came the Health Sciences Association of British Columbia (HSA). Despite the HSA’s large membership, the HSA’s degree of influence is nowhere near to the DoBC or BCNU.⁵

Some participants provided examples of where a policy to increase the scope of practice of one healthcare occupation would increase patients’ access to care services. Increasing scope of practice would benefit the occupation in question by permitting the practice of a greater skill set and providing education and experiential training, while diversifying the kinds of health professionals that patients could see for a specific service. However, in some circumstances, other professions took significant issue with the possibility of increasing the scope of other occupations. The arguments against increasing scope of practice is primarily related to the education and experience of the occupational group to perform the function, even to the basic first aid skills that most healthcare workers already have. These arguments were difficult to defend especially in rural and remote care situations with recruitment and staffing shortages. Rural and remote communities require all the healthcare staff that can recruit and retain.

Frequently, medical staff representation and influence came up in the interviews as multiple participants reflected upon crucial decisions and policy initiatives throughout the years at the Ministry of Health. One participant noted that “if the doctors did not like a specific policy or change, then it would be challenging to pass anything... you needed to have the doctors onboard.” Some examples were brought up during conversations regarding introducing new professions into the B.C. health professions, such as midwives and nurse practitioners. Another participant noted, “...it made no sense why it was so difficult to introduce midwifery as a profession since overseeing childbirth is one of the oldest jobs, but it was a significant challenge due in part that doctors had a concern regarding creep into the scope of practice and hesitation over the level of professionalism of midwives.” Nurse practitioners were another similar case where concerns regarding their scope and professional status came into question. A few participants noted that only when physicians’ concerns were addressed could any changes to scope of practice occur, and introduction of a new profession could happen.

A participant cited a recent example of the domination of physician issues with the changes to the compensation system of general practice physicians in B.C. While it is no question that general practice physicians were overdue for an improved compensation system, this massive change is indicative that the priority is still on primary care. To improve the quality of patient care and access to services, moving away from the primary care model to a team-based care approach is ideal, some participants noted. However, some of the participants speculated that due to the influence of medical staff and the ability to mobilize public attention to focus on physician specific issues, the public and government will continue the focus on primary care.

⁵ HSA is the union representing more than 20,000 professionals working in health and community social services in B.C. HSA represents health science professionals such as physiotherapists, occupational therapists, pharmacists, anesthesia assistants, and more (Health Sciences Association, n.d.).

This focus on a specific occupation in the discourse of healthcare occupations has direct implications on decision-making and demonstrates the strong influence that healthcare professionals have relative to other unregulated occupations. In the hierarchy of healthcare occupations, it is clear, especially in the perspectives of some of the decision-makers that physicians are on top.

Regulatory & Professional Advantages

Another theme that emerged from the interviews was that regulated professionals had multiple advantages due to the high perception of professional legitimacy by decision-makers and representation by a professional association. Midwives and nurse practitioners were brought up as examples of how to successfully form professional associations, to demonstrate examples in other jurisdictions of the benefits the occupation provided, and to establish post-secondary training programs to elevate their professional legitimacy and advance the occupation's interests. A couple of the participants noted that it was critical in these examples that the occupations had an organized, professional association to advocate on their behalf – without them, the efforts to attain professional legitimacy and professional status would not have been effective.

One participant noted that one of the typically overlooked unions, the HEU, which represents the majority of non-professional and unregulated occupations, was effective at advocating on behalf of its members. While Bills 29 and 94 led to mass layoffs and removal of most of the HEU membership, the HEU, in solidarity with other unions, led the charge to take the government to the SCC – and won. They could effect such significant change not only to the occupations that they represented but to other non-healthcare roles that were affected by similar legislation during that era. Further to the findings of Case Study #1, the HEU were not as effective in influencing decision-makers in comparison to other professional associations. The HEU had to resort to using the SCC to have the concerns of its occupations addressed.

The participants noted that in their work, most attention was placed on the regulated professions and occupations because they had more visibility in the priorities and work of decision-makers and policy departments. A couple of participants noted that, due to the broad scope and complexity of the health sector, there was not enough capacity to thoroughly consider unregulated occupations. Two participants noted that the HHR decision would be left to the health authorities, effectively making it a more operational and less strategic level of decision-making. Their respective human resources departments were responsible for identifying challenges and resolving policy issues with these occupations. One of the participants disagreed with the notion that non-professional occupations (such as dietary aides and housekeepers) faced challenges due to their unregulated and non-professional status because they were represented by their employers (i.e., health authorities, hospitals, and other medical facilities), their labour unions, and other entities such as WorkSafeBC.⁶ These last few comments are of particular interest to the following theme of over-professionalization, demonstrating that minimal attention is paid to unregulated and non-clinical occupations.

Regulatory and professional advantages are a major theme of professional legitimacy and occupational regulation in healthcare professions that emerged in the interviews. Participants

⁶ WorkSafeBC is a B.C. provincial agency with the mandate to oversee workplace safety standards and an insurance system for the workplace.

shared that regulated professionals had multiple advantages due to the high perception of professional legitimacy by decision-makers and representation by a professional association. The participants noted that most attention was focused on the regulated professions in decision-making and policy departments, leaving unregulated and non-professional occupations with minimal attention.

Over-professionalization

During the discussion, a participant raised concern about the growing trend of over-professionalization in various sectors, including HHR. Over-professionalization refers to the increasing demand for additional or higher credentials to practice in certain occupations. For instance, in B.C., physiotherapists initially required a bachelor's degree, but now need a graduate-level degree. Similarly, registered nurses in Canada during the 1980s moved towards requiring at least a bachelor's degree or more (Duncan, Scaia & Boschma, 2020). Participants noted that over-professionalization poses additional barriers to entry, particularly for those lacking the resources to pursue higher education.

In addition, higher-level credentials require more time and money, but do not necessarily guarantee graduates are ready to practice. This trend is worrying, particularly because it may lead regulated professionals being without practice ready skills and ill-equipped to perform their roles, while carrying massive responsibility and accountability for their work. Another consequence of over-professionalization is that it may reduce the number of unregulated healthcare workers in high demand to support professionals and patients. Over-professionalization may ultimately hinder the performance of a health professional who needs a team of unregulated healthcare workers to support the delivery of care.

There is a growing concern that professional roles are being given more attention than unregulated occupations due to factors such as higher pay, job security, and better working conditions. However, some interviewees suggested that attention on these occupations has come at the cost of availability of non-professionals who provide frontline and direct patient care. While medical staff are critical, the majority of healthcare workers do not require medical degrees to provide safe and effective care. Multiple participants noted that nurse practitioners, for example, who have advanced nursing degrees instead of medical degrees, offer comparable quality of care to some physicians.

Attention to Certain Occupations

Participants who were familiar with Case Study #1 noted that to take the work of non-clinical and unregulated non-clinical support workers for granted was one of the biggest mistakes in HHR by policy and decision-makers. This sentiment is also expressed in consideration of the importance of hygiene and sanitation during the outbreaks of COVID-19 in clinical settings. One participant called it a "big mistake of governments" to undervalue and overlook the work of the non-clinical workforce particularly because the critical services that they provide allow other professionals to practice and provide their services. This "big mistake" was the disregard of the role of the non-clinical workforce, mostly made up of unregulated health occupations, and the lack of attention or concern for these workers. Participants mentioned other examples of occupations that were essential in this capacity: housekeeping and environmental services, security and protection services. These roles are critical to the delivery of patient care and necessary for the healthcare system to function, as a couple of participants noted.

This oversight and limited attention to these non-clinical support workers are not only a policy issue for decision-makers; this is also true of the general population they serve. One participant noted that in popular media, shows that depict healthcare settings rarely have the main character as a non-clinical non-professional and often use someone like a housekeeper as a gag or for comedic relief. The general population is more concerned with these unregulated occupations when significant events happen where their work is blatantly necessary (e.g., a global pandemic) or when individual patients are affected by low-quality services during their interactions with the healthcare system.

Recognition of Occupation's Roles

Similar to the previous theme, many participants noted that there is limited recognition of the vital services these non-clinical unregulated occupations provide. One participant who provided advocacy support for these non-clinical support workers noted the blatant disrespect unregulated workers would receive from their colleagues simply because they were not as educated or did not have a similar professional status as others who worked on the floor.

A couple participants provided examples of attempts to “deskill”, reducing the level of skill required for the job, of non-clinical healthcare support roles to the point where the case would be made that anyone with no experience, skill, or training could do these jobs. This deskilling trend led to the further devaluation of the role of these occupations and ultimately led to abysmal working conditions, low wages, and high turnover. It also led to a decrease in the quality of services that affected patients and other healthcare workers. These roles became challenging and were perceived as ‘dead-end’ jobs with no upward mobility. Fewer people sought these roles as opportunities to work in the healthcare sector, even as an entry point to a future career as a health professional due to the devaluation of these roles.

Terminology of Professionalism

A couple of participants challenged the term “non-professional”. They recognized that while some occupations do not hold professional designations, most of these workers conduct themselves professionally. However, all acknowledged that defining professionalism is complex yet fundamental to being part of the mainstream healthcare system. A couple participants noted that other professions that experienced challenges to becoming recognized as a profession in the B.C. healthcare system were practitioners of traditional Chinese Medicine (TCM), naturopathic doctors, and Indigenous healers. Concerns were raised regarding the professional status of these practitioners as well as overlapping scope with other health professionals, namely physicians.

One participant further acknowledged the inherent colonialism within the concept of professionalism. Both TCM and Indigenous healers use modalities that are not traditional in Western medicine and do not align with Western medicine practices, yet have been practised for thousands of years. Some medical professionals do not see TCM or Indigenous healers as likely being able to provide equitable or complementary care to western medicine.

B.C. has begun the work to address Indigenous-specific racism in the healthcare sector. This finding that the terminology and concept of professionalism can be colonial and exclude competent healthcare professions should be examined further. This terminology is only one of the potential negative implications related to the overall culture and hierarchies in HHR and perpetuates barriers for patients to receive culturally safe and appropriate care.

Culture & Hierarchy

Another underlying theme in the interviews was the power of culture and hierarchy that affected all occupations. However, often, those near the bottom of the HHR hierarchy were most adversely affected. Culture and hierarchy may implicitly influence all aspects of decision-making and determine what occupations have the most professional legitimacy.

Many participants noted that interdisciplinary models or team-based care approaches led to better healthcare outcomes for patients but also correlated with more positive working environments and tremendous respect for services that every occupation on that team provides. While these models are innovative, the current culture and hierarchies impose barriers to team-based care due to the previously mentioned themes regarding the protection of scope and professional status. Some professionals are more open to working with others, but only with clearly defined roles and responsibilities.

In the example of unregulated health occupations in Case Study #1, the contracting out of the public system of thousands of workers created intense feelings of devaluation and alienation from the other public sector workers. These contracted-out occupations worked as privatized healthcare workers with limited protections, job security, and employee benefits while working alongside other public sector healthcare workers. These feelings of alienation do not allow for a positive work environment, which ultimately negatively affects patient care, as one of the participants noted.

In addition, participants mentioned that many workers in unregulated occupations do not feel safe to speak or raise concerns, especially against professionals. The same sometimes goes for professionals who are also lower in the occupational hierarchy. One participant noted that while there were always exceptions where a professional would speak out on behalf of an unregulated occupation, those opportunities were limited and occurred when speaking out was mutually beneficial. These hierarchical challenges were also something that some decision-makers mentioned they needed awareness of to weigh concerns and information adequately.

Public Servants

A common theme among participants was recognition that decision-makers relied on other public servants to make the best possible decisions. This theme was especially imperative from the former Ministers who noted the challenges of being assigned a cabinet portfolio that they might have little to no previous experience. From the Minister perspective, their working relationship with their Deputy Minister was one of the most important in the advisory capacity and they would also rely on other decision-makers, to provide expertise.

The majority of participants agreed that public servants are critical to providing the best evidence on which to base their decision-making but did not always examine the full political implications of policies. Ministers and Deputy Ministers were responsible for political decisions.

Government & Decision-Making

During the interview, a former Minister highlighted two political considerations that require attention in decision-making, including the justification and advocacy for the allocation of a significant portion of the global provincial budget to healthcare services. Participants noted that strong arguments were required to justify spending in one sector over another in a finite provincial budget.

Participants acknowledged the complex environment decision-makers must navigate, even for non-partisan decision-makers. They noted the challenge of maintaining impartiality and advocating for the right course of action while interacting with politicized groups, even if it's not palatable to certain occupations that may be directly or indirectly affected by HHR decisions.

Election cycles also played a significant role in political decision-making. Participants noted that healthcare policies require a significant amount of time to demonstrate effectiveness, but election cycles are often very short and make it difficult to implement policies that require long-term outcomes. As a result, some policies or decisions are paused or deprioritized depending on the timing of the election cycle. Some participants also noted that there was a significant influence from the political leadership, especially political decision-makers. It was noted that sometimes the political executive had the most influence and was the overriding factor in some health sector decisions.

The dominance of medical staff in healthcare discourse is another inherently political theme identified by many participants. They noted that physicians and groups representing physicians often create barriers for other healthcare occupations to increase their scope of practice or attain professional status through regulation by a college. This dominance has prevented the inclusion of other health professionals and created barriers for internationally educated health professionals to join the occupation. The B.C. HHR Strategy acknowledges the need to broaden the scope of practice for some occupations to counter the shortage of medical staff and increase collaboration in care through team-based or multidisciplinary clinics under the redesign cornerstone of the Ministry's HHR plan (Ministry of Health, 2022). However, participants noted that there is strong resistance to change. Thus, strong political will is necessary to advance systemic change.

Leadership

There were no direct questions in the interview regarding leadership. However, a couple of participants shared that, in their experience, leadership more than policy achieved results. A prime example is the COVID-19 pandemic, where strong and swift leadership resulted in the mobilization of efforts for a crisis response. Many measures were taken to address challenges that emerged. One of these challenges was the HCA staffing shortages in long-term care facilities. Since this was a major challenge, the B.C. government mobilized with the creation of the Health Careers Access Program (HCAP) which offered paid work-learn opportunities for those with no prior healthcare experience to become certified and practice-ready HCAs. The creation and implementation of the HCAP required centralized and swift action by leaders and decision-makers to implement a program that typically would require years to implement in the public healthcare sector, as noted by one participant.

Also, during the early days of the COVID-19 pandemic, some governments took a command-and-control response to the crisis for more effective coordination. The pandemic enabled faster responses to the crisis, and a more unified response across the health authorities and facilities.

Unfortunately, with the pandemic in the endemic phases, some noted that the sense of urgency has dissipated. During the pandemic there was more acknowledgement of the importance of HHR, but the sense of urgency has retreated to near pre-pandemic levels. The participant noted that this is unfortunate since the HHR issues require a similar approach like

how pandemic staffing shortages were handled to resolve challenges and need to be at the forefront.

One of the greatest opportunities where leaders can revolutionize HHR is by abolishing the hierarchy among health occupations and decision-makers and wrap the work and policies around patient care, one participant shared. A couple of participants noted that the hierarchies prevalent in the HHR and government will require leadership at all levels to make HHR policy more equitable.

Advantage & Disadvantage of Occupational Regulation

A couple of participants noted that the regulatory status of an occupation could be either a barrier or opportunity for the advancement of the occupation's interest in policy and decision-making. Most agreed that not every occupation needs to be regulated and not every occupation needs that professional status. However, some participants saw more opportunities for the advancement of the occupation when they were regulated and even greater opportunities when they were self-regulating professionals.

Also, some believed that regulation is also an opportunity to enable high-quality care and advance new strategies for HHR. Regulation is a policy tool, noted one participant, that can be used to establish and enable other HHR strategies.

The lack of occupational regulation was a detriment to some occupations getting the attention of policy and decision-makers alike. One participant explicitly noted that it was the regulated occupations that gained more attention, while others did not. An example brought up was an occupation that is unregulated in B.C. – perfusionists, who are necessary for cardiac surgeons. Despite their important role to enable a successful surgery, perfusion is an occupation with small membership and representation in the HHR workforce. Their perspectives are usually only heard when there the supply of perfusionists is especially low.

Consultation & Collaboration

Most participants reflected on the power of consultation and collaboration to advance specific policies and changes. Public servants impact health policy within the Ministry of Health, broader government, and other public servants, including those who work for health authorities, in varying degrees. These partners provide information necessary for informed decision-making and have the means to conduct further consultative work with additional partners affected by these changes.

Participants noted that in some cases, the collaboration and advocacy efforts of associations and unions and public consultation were the most effective in overcoming any barriers that an occupation faced. In the examples of midwifery and nurse practitioners, champions within the occupation were critical to providing examples of their effectiveness in other jurisdictions and gaining organized support from a professional association. For unregulated occupations, participants brought up the example of Bills 29 and 94 where unions for unregulated occupations and their partners organized to have their case heard by the SSC.

Consistently, the influence of patient voices attained through public consultations was an essential factor for decision-making. Patients said they would like more options for health services during regular government-led public consultations. A couple of participants noted that

the work led by public servants to consult with the public garnered evidence to support the need to prioritize the adoption and increase the scope of some professions and occupations.

While consultation and collaboration are critical for public policy development, participants noted that it is challenging in the complex healthcare system. This challenge is partly due to the multitude of partners and the wide diversity of opinions. One participant noted that compared to other ministries, where the approach is “command and control,” the healthcare system does not operate and cannot operate to achieve positive outcomes for patients and healthcare workers. “To achieve results and change, you must negotiate with all the groups,” one participant noted. “Every individual voice will not get heard,” one participant said, “however, the public servants and we try the hardest to engage and consult with as many people who will be affected. In some cases, this means hundreds of thousands of healthcare workers and even more patients.” Some decision-makers noted that in their roles, they tried to visit facilities to observe and talk to front-line staff. However, due to the demands of the job and the large geographical area of B.C., it is logistically challenging for any decision-maker to make frequent on-site visits.

All participants highlighted the importance of collaboration at all levels and environments to achieve the best quality of care and patient outcomes. However, large scale public consultations require significant resources and face logistical challenges. Yet, it is through collaboration with others that accountability occurs, especially for public sector policy and decision-making. It is also one opportunity to bring all points of view together and ensure that all perspectives are represented at the decision-making table. Multiple participants stated that consultation and collaboration is one area where innovations can help to increase efficiency and ease of public consultations and expand the reach of participants.

In addition to innovations to facilitate consultation and collaboration, a couple of the participants suggested that including labour unions and associations in more consultations would be beneficial. Unions speak on behalf of their members and can provide information to policy and decision-makers without being filtered through employers. This kind of consultation would also help smaller occupations, which do not have the membership numbers to organize a professional occupation to have their perspectives heard by decision-makers.

5.4 Summary

The case studies and interviews present interesting insights for reflection in the following discussion on perception of professional legitimacy of healthcare occupations. Case Study #1 reviewed the sweeping changes to unregulated non-professional healthcare occupations and the situational and legislative circumstances. Case Study #2 reviewed changes to the *Health Professions Act* and found that past attempts to change how B.C. regulates health professions were insufficient. The proposed changes in Bill 36 face criticisms by one of the most influential professions that will be affected, namely physicians. The subject matter expert interviews provide a variety of former decision-makers and leaders’ considerations of both unregulated and regulated health occupations. Interviewees also specified an emphasis on the challenges of professions and unregulated occupations, including barriers inherent in and concerns about the scope of practice and the perception of the professional status of healthcare occupations. In the next chapter, the case studies and the subject matter expert interviews will be analyzed to determine new and additional themes and to address the research questions.

5.5 Revisit of the Conceptual Framework

This study's conceptual framework (p. 16) outlined themes related to regulatory status, professional status, and influences on decision-making that emerged from the literature review. Participants reiterated some of these concepts. For example, the role and collaboration among decision-makers at various levels, the necessity of being regulated and a profession, the effectiveness of advocacy and representation from occupational groups, and culture and hierarchy were all important themes found in the case studies and interviews. Another important theme that emerged was the powerful influence of occupational hierarchies, which will be discussed in the next chapter and related to the conceptual framework.

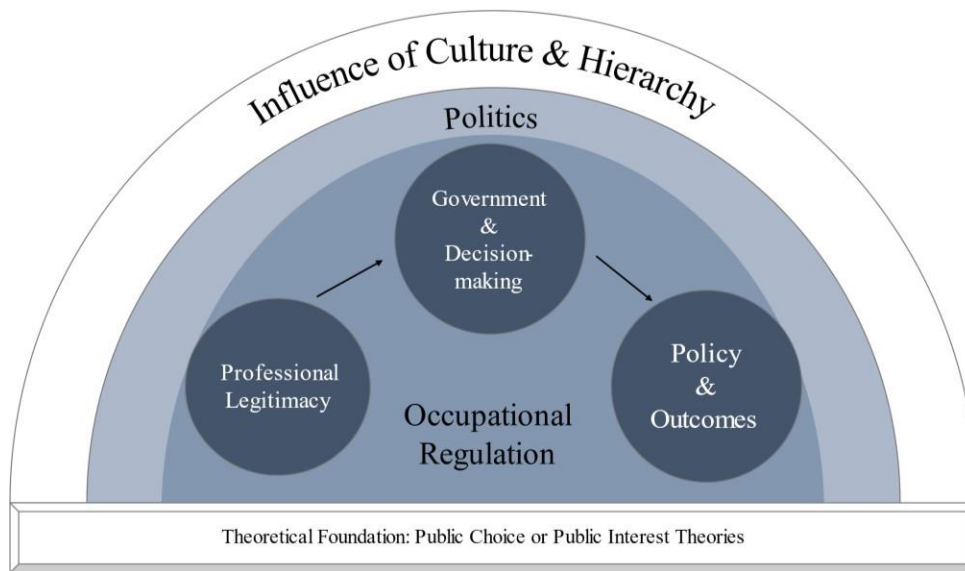
These themes are in alignment with the concepts in the conceptual framework as follows:

Government & Decision-making	
Legislation	Public Servants
Role of Decision-makers	Leadership
Challenges for Decision-makers	Consultation & Collaboration
Occupational Regulation	
Public Choice	Public Interest
Purpose of Occupational Regulation	Interests of Occupational Regulation
Advantages of Occupational Regulation	Disadvantages of Occupational Regulation
Culture & Hierarchy	
Authority	Recognition of Occupations' Roles
Access to Resources	Over-professionalization
Attention to Certain Occupations	
Professional Legitimacy	
Reliance on Professional Legitimacy	Terminology of Professionalism
Politics	
Power of a Single Profession	Influence of Unions and Associations
Politics of the Day	

In the interviews with former decision-makers it was evident that a fifth main theme was present, albeit not explicitly stated across the case studies. The influence of politics was mentioned a few times in the interviews, and after revisiting the conceptual framework a couple of the subthemes were sorted under the politics theme. In the two case studies, politics in a variety of forms emerged as an influence on the dynamics and conversations regarding the occupational status of healthcare workers. Decision-makers in the interviews also noted how in some cases politics or political influence was the driver behind a particular decision. The conceptual framework has been updated based on this new main theme in Figure 5.

Revisions were made to the original conceptual framework to underscore the prominence of the fifth theme, politics, in perception of professional legitimacy and HHR decision-making. The strong influence of politics aligns more closely with Public Choice theory, but the theme of politics and the subthemes manifest in the case studies and interviews. These themes are explored further in Chapter 6. While this influence is implicit in the theories in political economy, politics has been included more prominently in the revised conceptual framework to highlight its importance.

Figure 5. Revised Conceptual Framework



Chapter 6: Discussion and Analysis

This chapter unpacks the findings from the case studies and participant interviews and answers the following research questions:

- 1) Does the occupational regulatory status of healthcare workers impact their perceived legitimacy by decision-makers in B.C. HHR policy decision-making?
- 2) What are the potential impacts of the perceived legitimacy of healthcare workers by decision-makers on HHR decisions and how do they affect healthcare workers?
- 3) What possible measures could be implemented to mitigate the impacts of the perception of professional legitimacy in HHR policy and decision-making?

The final argument of this thesis is that the occupational regulatory status affects the perception of healthcare workers by decision-makers, and the answers amass in the research questions. This chapter further elaborates on the significant findings of the main themes occupational regulation, culture and hierarchy, government and decision-making, and professional legitimacy. The discussion and analysis also highlight the emergence of a workforce culture subtheme under the culture and hierarchy theme, as well as a new main theme – politics. Under the new theme, power of a single profession, and politics of the day are new subthemes, and influence of unions and associations are included in this theme. Chapter 6 concludes with an analysis of how the perception of professional legitimacy of healthcare occupations may affect healthcare decision-makers and decision-making, as well as areas for further research.

6.1 New Themes and Considerations

6.1.1 Culture & Hierarchy – Workforce Culture

Workforce culture is a theme that appears throughout the interviews and case studies. A few participants noted that when workers felt alienated and devalued due to being disrespected the working environment was more negative. Patients are being served in these work environments, so unpleasant work environment reflects on the quality of care. These unpleasant work environments also contribute to recruitment and retention challenges in these roles.

The previous point focuses on the workplace at the site level. However, there were also elements of negative culture in the broad healthcare workforce. Hierarchies in the health sector workforce clearly exist. The animosity between healthcare occupations in the hierarchy, becomes a challenge. Many participants noted clear examples of one occupation trying to prevent changes to another's scope of practice. These hierarchies require public servants and decision-makers to act as mediators between the occupations within the hierarchy.

Another aspect of workforce culture is recognition of the various sub-cultures and how other intersecting identities influence or increase socio-economic barriers. Women make up most staff in nursing and unregulated non-professional roles. Recent immigrants and racialized people are overrepresented in unregulated and nonprofessional occupations. People from lower socio-economic classes are also less represented in professional occupations (Banerjee et al., 2021; Cornelissen, 2021; Stinson et al., 2005). When there is limited recognition of the presence of these socio-economic identities, there are potential risks to perpetuating such disparities.

6.1.2 Politics – Politics of the Day, Power of a Single Profession, and Influence of Unions & Associations

Politics emerged as a core theme in the case studies and the interviews. In both of the case studies, political undertones appear in the different treatment of occupations by decision-makers pertaining to the power and influence of particular entities (e.g., government, associations, and occupations) and partisan politics in the stark differences between governing styles and framing of decisions. Three separate subthemes emerged - politics of the day, power of single occupation, and influence of unions and associations. While this study falls within the field of public administration, the political dynamic is a significant influence that ultimately guides the majority of strategic directions and determines the priorities of policies. Pessimistically, some decision-makers at the highest levels make decisions based on considerations of how a policy affects their voter base. We must notice the political, even at the nonpartisan levels; the awareness must be there to determine the feasibility of the policy within the political strategy.

Politics of the Day: The theme “politics of the day” in this thesis refers to the political ideology of decision-makers and the electorate who chose them. This theme has a powerful influence on decision-making and affects the sympathy decision-makers have towards certain occupations. Healthcare professionals higher on the hierarchy tend to have more representation in partisan settings, while unregulated non-professional workers rely on representation in politicized organizations like labour unions. Governing provincial parties over the decades have had unique relationships with unions and associations. For example, political decision-makers within the B.C. Liberal government were antagonistic towards labour unions whereas the BCNDP were closer in ideological alignment with unions.⁷

Political decision-makers often align themselves with the governing party, and this was observed in the answer from most of the participants in the study. This theme is strongly evident in Case Study #1, as some expressed that under the B.C. government from 2002 onward, the focus was to shrink the scope of the public service’s responsibility for public administration and reduce expenditures.

Furthermore, in Case Study #1, NPM was a potent influence on decision-making where the B.C. Liberal government contracted-out and privatized healthcare services. The current BCNDP government has undone most of these changes based on a different ideological interpretation of the *Canada Health Act* – namely expansion of public services. It is not within the scope of this thesis to determine which government’s approach produces better outcomes. Still, this study finds that the politics that guide the government of the day are a necessary consideration of policy analysts and decision-makers. Specifically, in the determination of HHR policy, politics of the day are critical since the implications may not be as evident but impactful to certain populations. However, this phenomenon does not explain all policies. There are still outstanding questions regarding why these unregulated healthcare workers were treated differently and disregarded while other regulated occupations did not have similar consequences.

Power of a Single Profession: A couple of participants said that professions in the healthcare sector are different from other unregulated occupations because attaining representation from a

⁷ In 2023 the B.C. Liberal Party changed their name and is now known as the B.C. United Party. For the purposes of this thesis, the party will be referred to by its former name.

regulatory college provides the occupation with a status of professionalism. While occupations in other sectors might also want to achieve recognition as professionals, this status is arguably particularly consequential in health care. As discussed previously, achieving professional status increases the perceived credibility of the occupation and provides greater attention from the Ministry of Health and its allocation of resources. Health care is the most significant expenditure of the global provincial government budget; however, resources are finite. It is understandable why some occupations would see it as necessary to become recognized as a profession to attain more resources and be viable.

As seen in some of the previous examples, politics is pervasive in determining which occupations can attain professional status, such as in the experience of midwives, naturopaths, nurse practitioners, midwives, and TCM. Here “politics” refers to the power and authority that some healthcare occupations have to influence HHR policy for other occupations. When one professional occupation has significant authority and influence that determines the outcome of other occupations attaining their professional or regulatory status, that influence appears through their power to shape the policies affecting another occupation. Interview participants noted that in their roles as healthcare decision-makers, another layer of responsibility was to mitigate the challenges between the occupations. The proposed changes to the *Health Professions Act* include a new formula to determine which professions and occupations should be regulated, which may reduce the politics and friction that emerge between occupations.

Influence of Unions & Associations: Unions and associations are cited in the case studies and interviews as highly influential in the advocacy of HHR policies, and in some cases, that influence is determinative of how specific occupations are regulated. The degree of influence can be seen as a political tool, which may effect the allocation of finite resources and attention to specific causes. Occupations that sought and successfully achieved regulation were represented by strong unions and associations who could lobby and advocate in the occupation’s interests. Physicians were frequently cited in the interviews as the most influential in HHR policies across the health sector by participants due to the strength of their association, the DoBC.

One participant noted that labour unions like the Hospital Employees’ Union (HEU), which represents the majority of non-professional and unregulated occupations, were typically overlooked by the public and decision-makers. To compensate for the lack of attention, the HEU required additional support from other labour organizations to organize and challenge the government at the SSC and ILO. The HEU’s effectiveness on behalf of unregulated occupation was not directly influencing decision-makers in government. Unlike the regulated professional advocacy organizations who represent physicians and nurses, the DoBC and BCNU respectively, unions representing unregulated workers had to resort to the courts to have the voices and concerns of its occupations addressed.

6.2 Answering the Research Questions

6.2.1 Does the occupational regulatory status of healthcare workers impact their perceived legitimacy by decision-makers in B.C. HHR policy decision-making?

In both case studies and interviews with former decision-makers, it is evident that multiple factors, such as the occupational regulatory status of healthcare workers, affect the perceived legitimacy and perpetuates the occupational hierarchy. Examination of the case studies

found that unregulated healthcare workers had to go to great lengths, such as challenging the decision of the B.C. government at the SSC and filing complaints to the ILO, to have their concerns heard (Banerjee et al., 2021). Case Study #2 showed that while regulated healthcare occupations have a high perception of professional legitimacy by the public and decision-makers, partially due to the strict entry and educational requirements to attain a professional designation, several high-profile instances occurred that pressed the government to update the professional regulation of healthcare occupations as recommended by the Cayton Report (Cayton, 2018). Interview participants covered a variety of themes in which occupational regulatory status affected the perception of professional legitimacy and recognized that it was a factor in some cases of HHR decision-making. Several subthemes emerged to answer this question, including interests in regulation, access to resources, recognition of occupations' roles, over-professionalization, reliance on professional legitimacy, decision-makers challenges, influence of unions and associations, and power of a single profession.

Occupational Regulation – Interests in Regulation: At the beginning of this thesis, multiple reasons why occupations would want to be regulated were cited, including attaining greater professional legitimacy, access to resources, and attention from decision-makers. All those reasons are seen in the case studies and interviews. Case Study #1 shows how unregulated occupations did not have the same benefits or opportunities and faced several hurdles due to the lack of regulatory status. In Case Study #2, regulated occupations had various benefits of professional legitimacy, to the point where the lack of professional conduct of some health professionals were overlooked for years. Former decision-makers in the interviews cited midwives and nurse practitioners as examples of how these occupations required formal organization by a professional association to elevate their professional legitimacy and advance their interests. A couple of the participants noted that it was critical in these examples that the occupations had an organized, professional association to advocate on their behalf – without them, the efforts to attain professional legitimacy and status would not have been effective.

Culture & Hierarchy – Access to Resources: Professional legitimacy may influence which occupations have access to a variety of resources. This influence is due to the culture of hierarchy, where occupations that are higher on the hierarchy have greater access to resources. As observed in the literature review, the B.C. Health Human Resource Strategy has limited discussion of unregulated healthcare occupations, while dedicating action to implement GBA+ across the healthcare sector (Ministry of Health, 2022). This strategy is also an example of how unregulated occupations do not have the same access to resources as regulated occupations. Some of those resources can be monetary, for example allocation of funding from the HHR budget, or non-monetary such as the access to decision-makers. In Case Study #1, unregulated healthcare occupations lost their access to the public healthcare sector by being contracted out of the healthcare sector with Bills 29 & 94. In Case Study #2, the regulated healthcare occupations have relatively more resources and access to decision-makers. It is also seen that these professionals also had greater access to additional resources through the representation of associations and interest groups that could organize and lobby decision-makers. Participants in the interviews also acknowledged that professionals had greater access and allocation of resources, and access to decision-makers. Some participants also acknowledged that the professional occupations typically required significant resources and that could also increase the awareness and recognition of these roles.

Culture & Hierarchy – Recognition of Occupations’ Roles: Consistently through the case studies and interviews, the recognition of occupations’ roles in the healthcare system was highlighted and demonstrated to be another indicator of the perception of professional legitimacy impacting healthcare decision-making. Thousands of unregulated healthcare occupations were contracted-out of the public system as a cost saving measure, but that did not happen to regulated healthcare occupations as seen in Case Study #1. These worker’s roles were seen as unimportant in the delivery of healthcare services, and in the cases of dietary aides and housekeepers were seen to provide services more similar to those in the hospitality sector than the health sector. Bills 29 and 94 reflect the influence of culture and hierarchy of healthcare occupations in the legislative provisions that have not always served the best interests of workers, especially those who are lower on the occupational hierarchy. In Case Study #2, where most of the discussion and focus is on regulated health professionals, the importance of their work is consistently acknowledged and considered in all the changes to the *Health Professions Act*. In the interviews, some participants stressed that health professionals, usually physicians, were the most important voices informing decisions, some even acknowledging that physician approval was necessary in the development of any HHR policies. Some participants also noted that because of the emphasis on the perspectives of physicians in HHR policy and decision-making, information from regulated health professionals were more important and relied upon to make decisions. This high value placed on information coming from health professionals has also translated in the need for other occupations to increase the level of professionalization and raise expectations of various decision-makers, as at least one interview participant reflected.

Culture & Hierarchy – Over-Professionalization: The strong presence and benefits of professional legitimacy can also be found in other concepts in HHR such as the trend for occupations to become more or over-professionalized. Government and decision-makers spend more time and resources on regulated health occupations, as established in the case studies and interviews. However, there is a trend for occupations that were unregulated for some time to advocate for their regulation and for some occupations to require additional requirements to attain professional status. This trend also raises questions regarding the necessity for additional requirements for entry into the occupation, especially during a shortage of workers in HHR. However, these trends show that more occupations are striving for professional status and legitimacy, and that might be due to decision-makers' reliance on professionals.

Professional Legitimacy – Reliance on Professional Legitimacy: Decision-makers seek and receive information to inform policy and decisions, usually from professionals due to their legitimacy as subject matter experts. As some participants noted, subject matter experts are critical sources of advice for HHR decisions. Subject matter experts are typically professionals in their own occupations and hold a high degree of knowledge. However, those same subject matter experts may also have other priorities and interests and can use their professional legitimacy as an avenue to lobby decision-makers to adhere to their wants. Balancing the interests that come from different sources of information through subject matter experts is one of the various challenges that decision-makers face.

Government & Decision-making – Decision-maker Challenges: Recognition of the difficult role and responsibilities of decision-makers is necessary especially in matters affecting significant changes to a wide population of people. Many decision-makers must balance multiple interests of groups, such as the public, patients, and occupations. Decision-makers have multiple interests that they must be accountable to, including the public and political decision-makers, and may not

always have the direct access to information required to make informed decisions. Those conflicting interests are why many decision-makers look towards professionals, especially in specialized areas such as health care, to provide the knowledge.

Politics – Influence of Unions and Associations: Unions and associations represent groups of workers with knowledge of their occupation and working conditions. In Case Study #1, there are stark differences in the perception of importance and legitimacy of certain unions and associations. In the early 2000s, the government of the day revoked access of unregulated healthcare occupations to representation by a union. Although they represented the majority of unregulated health occupations and workers, these unions were perceived as less legitimate and unnecessary in HHR. Some of the participants also acknowledged that, while the perceptions have shifted regarding the role of unions and associations within government, groups that represent unregulated occupations are treated differently than groups representing regulated occupations. Multiple participants noted that decision-makers are more likely to be closely aligned with groups, such as DoBC, than with unions. This alignment demonstrates that occupations benefit from professional legitimacy and is another example of a certain profession influencing decision-makers the most.

Politics – Power of a Single Profession: Case Study #2 and the interviews highlight the impact of healthcare occupational regulation's regulatory status on decision-makers' perceived legitimacy. Physicians exercise the most influence on their own occupation and other occupations' regulation, as illustrated in Case Study #2 and the interviews. Although some physicians opposed certain aspects of Bill 36, they remained prominent in the consultation process. Interviews revealed physicians' dominance in conversations on regulating other professions like midwives and nurse practitioners. Physicians' concerns about overlapping scopes of practice affected the quality of care, and their influence delayed or prevented occupational regulation and recognition of other professions. The power of a single profession illustrates the varying degrees of legitimacy's effects on HHR decision-making.

Summary: The occupational regulatory status of healthcare workers does impact the perceived legitimacy of these workers by decision-makers in B.C. HHR policy decision-making. The case studies and interviews revealed that regulated healthcare occupations enjoy a higher perception of professional legitimacy by the public and decision-makers. This phenomenon is partly due to the strict entry and educational requirements for regulated professions. Unregulated healthcare workers often face significant challenges and have to resort to legal actions to be heard. The recognition of occupations' roles in the healthcare system also plays a part, with regulated professions receiving greater attention and resources. Decision-makers often rely on professionals as subject matter experts, which further reinforces the influence of professional legitimacy. Unions and associations representing regulated occupations tend to have more influence in decision-making processes, while those representing unregulated occupations are often treated differently. The dominance of a single profession can also shape HHR policy and decision-making, delaying or preventing the regulation and recognition of other professions.

6.2.2 What are the potential impacts of the perceived legitimacy of healthcare workers by decision-makers on HHR decisions and how do they affect healthcare workers?

The potential impacts of the perceived legitimacy of healthcare workers by decision-makers can be as minimal as a minor change to operational policy, to sweeping such as affecting the culture of the workforce. The variety of impacts is seen in both case studies and in the

interviews. In Case Study #1, unregulated healthcare workers were contracted-out of the public healthcare system to be employed by multinational corporations to deliver services. Operational policy and contracts were managed by health authorities, but ultimately these healthcare workers were employees of corporations who primarily provide services in the hospitality sector. These healthcare workers saw Bill 94 restrict their rights to be represented by a union. Wages were halved, and workers were subjected to precarious working conditions (Banerjee et al., 2021; Ministry of Health, 2021, 2018). Regulated healthcare professionals, in Case Study #2, benefited from having a high degree of professional legitimacy in their roles through the protection of their scope and being self-regulated (Ministry of Health, 2020). Some occupations advocate and lobby the public, government, and decision-makers to have their occupations regulated so they can also have similar benefits and prestige of being regulated. Decision-makers interviewed as well agreed that there were multiple impacts of professional legitimacy, including affecting the overall workforce culture, what groups government will consult on HHR policy and decisions, and the occupations that they will consult with on HHR decisions affecting other occupations. Some subthemes covered for this question are the interests in regulation, access to resources, workforce culture, role of decision-makers, legislation, and terminology of professionalism.

Occupational Regulation – Purpose of Regulation: Regardless of whether a Public Choice or Public Interest theory is adopted as a rationale for the approach to occupational regulation, in the case studies and interviews there are multiple examples of how professional legitimacy can influence governments' choice to regulate. In Case Study #1, the move to contract out unregulated healthcare workers was a measure to cut spending, but it also led to the reduction of policies and regulations of the protecting the working conditions of unregulated healthcare workers. While red-tape reduction was a frequent goal of the government in the early 2000s, unregulated healthcare occupations saw more deregulation and offloading of policy responsibilities to free market enterprises (e.g., multinational corporations) relative to regulated occupations and health professions. In Case Study #2, some occupations that were already regulated were spotlighted for unprofessional conduct, and led to significant questions regarding the purpose and efficacy of the models of occupational regulation in B.C. In Cayton's (2018) report, in Case Study #2, a review of failures of the *Health Professions Act* that led to the purpose of regulation not being fulfilled and demonstrated why and how governments should regulate healthcare occupations. Finally, some of the interview participants noted that regulation for the sake of regulation was not helpful and could create additional barriers to care. However, participants also acknowledged that they understood why some occupations would see an interest in regulation and why those occupations would advocate that there was a valid purpose for their occupation to be regulated.

Occupational Regulation – Public Interest Theory: From a Public Interest theory perspective of professional regulation, it was noted by interview participants that increasing the scope of practice for certain healthcare occupations could improve patient access to care services, especially in rural and remote communities where staffing shortages are common. Although some, notably physicians, argued against this expansion, citing concerns about the education and experience of certain occupational groups, such arguments were difficult to defend in situations where access to health care was limited. Moreover, permitting the practice of a greater skill set through increased scope of practice would benefit not only the healthcare occupation in question but also diversify the kinds of health professionals that patients could see for a specific service, ultimately serving the public interest. Therefore, it is important to consider the public interest

when regulating healthcare professions and to ensure that such regulations serve to improve patient access to essential healthcare services.

Occupational Regulation – Interests in Regulation: The interviews revealed concerns regarding infringement on the scope of practice of healthcare professionals as part of an occupation's concerns regarding regulation. These concerns arose because professional status includes claims to specific skills and knowledge claims. If scope is too freely given to another occupation or too many healthcare professionals can practice the same restricted activities, then that diminishes the exclusivity and prestige of the professional status. The literature cites this as one motivator for health professionals being protective of their scope. Participants shared that a common argument that they heard from health professionals opposing the regulation of new occupations touched upon concerns pertaining to scope of practice, that were framed as concerns for patient safety and quality.

In Case Study #2, it is understandable why some professionals, particularly physicians, would oppose any changes streamlining the process for other occupations to become professionally regulated. Changes to the *Health Professions Act*, and the inclusion of additional regulated occupations, may bring more competition in the market for some health services. Professional legitimacy and scope of practice is a zero-sum game for some professions. One occupation must lose some of their protection of their scope of practice for another to acquire professional legitimacy. Unfortunately, this creates a competitive environment among occupations that does not foster collaboration.

Finally, throughout this thesis and the literature, there are references to the advantages of being regulated. In some cases, a significant barrier to attaining any degree of professional legitimacy was the lack of occupational regulation. Several of the interview participants noted that they understood that some occupations would advocate to become regulated to attain greater access and professional legitimacy. Once an occupation is regulated numerous benefits emerge, including improved reputation among the public and access to resources.

Culture & Hierarchy – Access to Resources: This research suggests that having professional status allows for increased resources dedicated to ensuring the basic administrative tools are in place for the creation of a regulatory college for that occupation. Creation of a regulatory college also may increase public awareness and sense of trust that there is a dedicated oversight body to ensure the safe delivery of services. However, in the Cayton report from Case Study #2, we see that a regulatory body's presence does not necessarily equate with efficacy. As seen in Case Study #1 and in the interviews, not much attention is allocated to unregulated healthcare workers and the effects of HHR policy. This limited attention can be due to health authorities and facilities specifically overseeing the HHR policies of these unregulated healthcare occupations. Since the responsibility for the oversight of HHR policies are mostly with health authorities and facilities, government may not pay much attention to these unregulated occupations or have insights into the roles of these workers. While health authorities have this oversight, this approach also fails to account for the role of the provincial government in setting HHR strategy.

Culture & Hierarchy – Workforce Culture: The perception of professional regulation has a significant impact on HHR strategy, which affects the workforce culture. Cultures that enable or restrict attempts to implement HHR strategies are seen in multiple articles throughout the HHR

and occupational regulation literature. While legislation and policy play a role in shaping norms and procedures, they cannot transform workforce culture.

Case Study #1 and a few interviews have shown how massive changes can negatively impact workforce culture, with the example of an unregulated occupation being alienated from the public sector. Despite the relevant legislation being repealed for numerous years, the negative implications to the cultural fabric are still felt by unregulated occupations. In Case Study #2, the relationship between associations and health professionals was mentioned as another cultural aspect with different professions and associations having their own specific subcultures.

The specific culture of healthcare professionals is important to discussions about HHR strategy. Decisions affect culture, which shapes perceptions based on regulatory status with some occupations facing barriers and concerns from medical staff due to historical perceptions of their status. Examples from the interviews include midwives, TCM, and Indigenous healers who were not perceived as medical professionals in the same way as physicians. Changes are underway in the B.C. to recognize other modalities and reduce barriers to culturally safe care.

Government & Decision-making – Role of Decision-makers: Professional legitimacy impacts how decision-makers perceive occupations, the issues at hand, and information sources. As mentioned throughout this research, decision-makers have a difficult role and require making widely impacting decisions that can have long-lasting effects on affected populations. Professional legitimacy may assist decision-makers to consider which information and arguments are the most valid or are in the best interests of the public, as some interview participants noted. We also see a couple of examples where the perception of professional legitimacy was very high, for example, with dentists, that could have possibly led to decision-makers to overlook the serious issues that were occurring by some professionals in Case Study #2. A couple of participants also shared that health professionals were most often the ones to consult directly with public servants and decision-makers on any significant HHR policies or decisions. As one participant noted, any legislation that did not make all physicians happy would be incredibly difficult to enact.

Government & Decision-making – Legislation: Legislation is fundamental to regulating occupations. Decision-makers and other public servants shape the laws that enable safe and high-quality health services. Legislation is foundational, but it also reflects the day's social norms and values. However, as we see in both case studies, legislation must keep pace with the challenges and values of the day. Significant decisions and legislative changes in Case Study #1 were made in the early 2000s based on precedents in Canadian labour law and were quickly ruled unconstitutional since the interpretations had changed over the years (p. 28).

Similarly, the *Health Professions Act* in Case Study #2 required modernization to address emerging challenges. Due to the rapid changes in innovations, technology, and patient demands, health care is one of the most challenging sectors to maintain modern laws and legislation. That is why Cayton (2018) and the recommendations in the Committee Report (2020) address such challenges by introducing legislative mechanisms such as a risk-assessed model to evaluate which occupations should be regulated. With the rapid advancements in health care, it is a matter of when new occupations emerge and lobby to be recognized as professionals in the legislation.

Professional Legitimacy – Terminology: In healthcare occupations, the terminology of professionalism has significant implications for the professional legitimacy of certain healthcare professions. Some participants in the discussions questioned the use of the term ‘non-professional’ and emphasized that many of these workers conduct themselves professionally despite lacking a formal professional designation. However, professionalism is complex and being a professional is fundamental to being recognized as part of the mainstream healthcare system. Certain professions, such as TCM, naturopathic doctors, and Indigenous healers, have faced challenges in acquiring recognition as legitimate professions within the healthcare system. These professions have faced criticism regarding their professional status and claims of overlapping scope with medical staff.

It is important to recognize that the concept of professionalism can be inherently colonial and exclusionary towards competent healthcare professions, such as TCM and Indigenous healers that use modalities that are not traditional in western medicine. This exclusionary connotation perpetuates a culture of hierarchies in HHR and creates barriers for patients who need culturally safe care. As B.C. continues the work of addressing Indigenous-specific racism in the healthcare sector, it is crucial to examine in depth the potential negative implications of the terminology and concept of professionalism that could perpetuate this colonialism and exclusion within the health care.

Summary: The perceived legitimacy of occupations by decision-makers can have a range of impacts on HHR decisions that affect healthcare workers. These impacts can vary from minor changes in operational policies to larger effects on workforce culture. Regulation offers advantages for occupations such as improved legitimacy and access to resources. Decision-makers and professional regulation can shape workforce culture and have long-lasting effects. Legislation as well is fundamental for regulating occupations, but it must keep pace with emerging challenges. It is important to examine the potential negative implications of professionalism terminology and its exclusionary nature in the healthcare context.

6.2.3 What possible measures could be implemented to mitigate the impacts of the perception of professional legitimacy in HHR policy and decision-making?

The final research question was developed in consideration of the potential impacts of the perceptions of professional legitimacy on HHR policy and decision-making and reflecting on potential effect mitigation strategies. As discussed in the last section, there are several potential impacts of the perceived legitimacy of healthcare workers disproportionately affecting those who are in unregulated healthcare occupations, that are overrepresented by immigrant, women, persons of colour, and less educated. Those that benefit the most from the positives of professional legitimacy are those who are in well established professionally regulated healthcare occupations, typically those that rank higher on the hierarchy of healthcare occupations (p. 8). Many interview participants offered ideas on how to level the playing field, specifically in policy and decision-making, including greater consultation and collaboration with all healthcare workers, and inviting groups or associations who represent these workers into conversations with government policy and decision-makers. Possible measures that can be implemented can include legislation, leadership, integrating Public Interest theory into occupational regulation, and consultation and collaboration.

Government & Decision-making – Legislation: As seen in both case studies, legislation was the most substantive tool used to shape the HHR policies of occupations. Case Study #1 showed how

one set of legislation (Bills 29 and 94) led to sweeping changes that were reversed a decade and a half later by another piece of legislation, Bill 47 (Ministry of Health, 2021; Vescera, 2022). In Case Study #2, the outdated *Health Professions Act* led to a series of controversies requiring an independent review. Cayton's report and the Steering Committee on Modernization of Health Professional Regulation informed that new legislation is required to begin systemic changes to how health occupations are regulated in B.C. (Ministry of Health, 2020). Legislation determines which occupations are regulated and in what way. Participants in the interviews agreed that legislation is one of the most fundamental tools that affect the professional status of occupations since it grants occupations professional occupation status, which is required to have professional legitimacy. If legislation can be used as a tool to effect change and mitigate the implications of the perception of professional legitimacy, provisions to ensure that health occupations are properly consulted or that measures are taken to mitigate the potential influence of other occupations can effectively change behaviours. This behaviour change can include decision-makers requiring greater consultation with underrepresented occupations or further filtering of some comments from relatively powerful interest groups, such as physicians.

Legislation is not enough, as some interview participants noted; in most cases, it requires leadership by decision-makers to pursue the complex and cumbersome process to create, draft, and enact legislation. Passing legislation requires significant resources to implement change, especially when the legislation either is addressing the whole HHR system or multiple occupations. The benefits of enacting legislation must outweigh the costs. Determining whether legislation of that magnitude is worth pursuing requires strong and coordinated leadership.

Government & Decision-making – Leadership: Leadership emerged as a force behind HHR policy and decision-making throughout the case studies and interviews. In Case Study #1, it was the leadership of decision-makers to enact different sets of legislation and defend their choices when critics challenged them. On the other hand, it was also the leadership of the labour unions that helped with the organizing and coordination of efforts to pursue a Supreme Court of Canada challenge and complaint to the ILO. Likewise, in Case Study #2, the leadership was required to take action to address controversies among certain health professions that ultimately led to significant changes to healthcare occupational regulation. Leadership was also required to address concerns raised by healthcare professionals that typically dominate the discourse of occupations and ultimately pursue a direction that benefits all occupations and not only one. Participants in the interviews provided examples of where leadership was seen as an important tool in HHR policy and decision-making. Examples such as the swift and direct response to the COVID-19 pandemic, as well as changes to the *Health Professions Act* to include naturopathic doctors, TCM, midwives, nurse practitioners, and others were cited as strong leadership that occurred against the pressures from groups like physicians who did not see a benefit to have their scope of practice overlap with other professions. Leadership is seen to be necessary, and its effects were exponentially increased when decision-makers could articulate how decisions are in the public's interests.

Occupational Regulation – Public Interest Theory: All public servants are responsible for serving and working in a way that benefits the interests of the public, including policy and decision-making in the public interest. While decision-makers may suggest that their decisions are in the public's interests, their policies and legislation might include loopholes that allow for entities, such as particular occupations, to use the legislation in their interests. These loopholes are the target of criticisms of the *Health Professions Act* seen in Case Study #2, and what led to

Bill 36. The new proposed legislation includes mechanisms to inform which occupations should be regulated, based on the foundations of Public Interest theory. Furthermore, interview participants also noted that considerations of what was truly in the public's interests, instead of information or lobbying efforts from specific interests groups or occupations, assisted with the mitigation of any bias towards a specific occupation based on their professional status. Most of the time this information to assist with the evaluation of what was in the public's best interests came through direct consultation and collaboration with affected populations.

Government & Decision-making – Consultation & Collaboration: The subtheme of consultation and collaboration has appeared numerous times throughout this research, as it has been seen to be another effective tool to influence HHR policy and decision-making. The presence of consultation and collaboration is an influential factor in decision-making in both case studies. What is also important is who is consulted in these decisions. In this research, multiple instances are identified where unregulated occupations would not be consulted even in major decisions affecting their work. On the other hand, regulated professionals, such as physicians were always consulted with even on matters that may not have direct impacts on their work. Some interview participants also noted that the limited representation of some of these occupations was one potential reason they were not typically consulted by government. This lack of representation could lead to some groups and occupations to be continuously omitted from HHR conversations. Some of the former decision-makers stated that one potential mitigating factor to diffuse the influence of professional legitimacy would be for the government to have more formal opportunities to consult and collaborate with different unions and associations that represent unregulated occupations. In the cases cited by interview participants, for example in the cases of midwifery and nurse practitioners, having formal opportunities for consultation helped with better collaboration and HHR decisions. It also would improve the overall recognition of the roles of all occupations regardless of their professional and regulatory status.

Summary: Measures to mitigate the effects of the perception of professional legitimacy in HHR policy and decision-making include legislation with provisions for consultation, strong and coordinated leadership, adoption of a Public Interest theory in legislation, and fostering consultation and collaboration with all healthcare workers, including those in unregulated occupations. These measures aim to address the disparities caused by the perception of professional legitimacy and promote fair and inclusive decision-making in the healthcare sector.

6.3 Limits of Analysis

The first research question investigates perceptions of professionalism in occupational healthcare regulation by decision-makers. However, the study has limitations, including a small sample size and difficulty in recruiting former decision-makers in less visible roles (e.g., former Executive Directors and Directors). Additionally, the study did not have direct access to current health authority staff and front-line healthcare workers but recruited participants with previous health authority affiliations and used indirect sources for front-line staff perspectives. The study does not analyze the normative question of healthcare regulation but focuses on the interaction of regulatory status and the perception of professionalism and provides recommendations to mitigate the impact.

6.4 Areas for Further Research

This study overlaps with multiple fields and provides numerous opportunities for further investigation. Standardized behavioural assessments could be used to examine individuals' perceptions from a psychological perspective. However, directly correlating regulatory status and perception of professional legitimacy requires more than behavioural assessments that may yield a recognition of biased experiences.

Studies have shown that policy and program analysts favour specific sources depending on the organizational source of information (Doberstein, 2017). Policymakers' perceptions may be skewed as a result of their favoured sources. Future research could focus on how policymakers perceive different healthcare occupations, as this affects the perception of legitimacy. In addition, examining power dynamics between healthcare occupations could help to better understand these professional relationships. Consultation and collaboration are also areas for future research, given their complexity due to the large number of participants to consult.

Finally, the Canada's occupational regulation in the healthcare sector is under studied. Using cases and recommendations from non-health or private sectors to base HHR policies and decisions may be ill-suited in the healthcare context. Further examination of regulatory policies in Canadian health care would provide richer academic literature.

6.5 Summary

This chapter analyzed the findings of the two case studies and multiple interviews to answer the three research questions of this study. In the analysis, politics is another theme that emerged along with the subthemes of politics of the day, power of a single occupation, and influence of unions and associations. Another subtheme of workforce culture also appeared under the theme of culture and hierarchy. Through examination of the case studies and interviews, the main themes of occupational regulation, culture and hierarchy, government and decision-making, and professional legitimacy and the new politics themes were discussed. Occupational regulatory status of healthcare workers does impact the perceived legitimacy of these workers by decision-makers. There are several potential impacts of the perceived legitimacy of healthcare works by decision-makers, including whose interests are served by regulation, access to resources, workforce culture, role of decision-makers, legislation, and terminology of professionalism. Finally, measures could be implemented to mitigate the impacts of the perception of professional legitimacy, including legislation, leadership, adopting a Public Interest theory to occupational regulation, and consultation and collaboration.

In the next and final chapter, answers to the question regarding the measures are further examined to provide a few tangible recommendations, along with some closing remarks regarding this research.

Chapter 7: Recommendations & Conclusion

This research aims to increase the understanding and awareness of the impact of professional legitimacy in provincial HHR decision-making. The research findings and analysis convey that occupational regulatory status affects the perception of professional legitimacy by decision-makers of healthcare occupations. This chapter synthesizes the findings and analysis into appropriate recommendations for provincial health administrators on how to mitigate the potential impacts of the perception of professional legitimacy and improve equity in HHR decision-making among health occupations.

7.1 Recommendations

The following recommendations are based on the case studies, interviews, and analysis. These recommendations are specific to provincial HHR policy makers, administrators, and decision-makers.

7.1.1 Recommendation #1: Embed inclusive government consultation and collaboration in all major HHR policy and decision-making.

B.C. has a robust public consultation framework that includes using digital tools to engage in a variety of topics. Consultation and collaboration are also one of the seven pillars of the B.C. HHR Strategy (Ministry of Health, 2022). However, such tools could be better used when engaging in consultations with various healthcare occupations. Some participants cited that too often only traditional channels were used for consultation, or in some cases engagement was focused on a small sample of the impacted population, or the same few groups were consulted with frequently. This recommendation could also include government establishing partnerships with organizations who represent these workers, such as labour unions and associations, to have more frequent channels of collaboration. For example, the government can be more explicit in their communication and engagement strategies to include groups at every stage of policy and decision-making.

Embedding more inclusive government consultation and collaboration will help with creating greater equity among different healthcare occupations. All roles within the healthcare sector are seen as important to the daily function of the healthcare system. Involving healthcare professionals and regulatory bodies in collaborative decision-making could help build trust between government and occupations and increase transparency with HHR decision-making.

7.1.2 Recommendation #2: Use GBA+ lens to identify all impacts on healthcare workers.

In alignment with the B.C. government's commitment to conduct Gender-based Analysis Plus (GBA+) in the BC HHR Strategy, another recommendation is for the HHR to use this lens at all stages of the HHR policy and decision-making process (Ministry of Health, 2022). GBA+ has been a tool that other jurisdictions have adopted to identify the potential impacts of policies and programs on a variety of identities. For example, the Ministry of Health can examine all policies and programs with a GBA+ lens to identify the potential impacts of different healthcare occupations. This type of analysis will require greater attention to identities related to class, education status, language, race, and immigration status to determine potential outcomes.

This recommendation would allow for robust information to be collected regarding the potential impact on populations, such as unregulated healthcare workers, that can be used to

inform key HHR decisions. This recommendation would require additional resources for the public sector to ensure that all public servants in policy and program development have the required skills to conduct such an analysis with a GBA+ lens.

7.1.3 Recommendation #3: Integrate a public interest perspective in HHR legislation.

While public servants are expected to serve in the public's interest, taking explicit steps to integrate a public interest perspective in HHR legislation and policy would help to change the HHR culture and entrench those values in all HHR decisions. As seen in both of the case studies, legislation was one of the fundamental tools that led to sweeping policy changes in health care, and ultimately impacted the workforce culture. Most legislation includes a preamble or note declaring that the legislation is in the best interests of the public; the actual implications may not align with those intentions.

By integrating Public Interest theory into the fundamental HHR legislation, the outcomes could include systemic changes overtime and create a more inclusive and collaborative workforce. For example, legislation could include explicit language indicating that the legislation is in the public's interest and include how it will fulfill that intention. The HHR legislation would also include clauses that set measures that align with the Public Interest theory, such as Bill 36 has the risk assessed model to evaluate whether an occupation such be regulated in the public's interest. Integrating a public interest approach may lead to substantive cultural shifts of HHR policy and decision-making because the public's interests are codified in law. Strategic and operational policies build on legislation and the values embedded within. This change will be slow, but it can yield positive effects in the long-term such as enablement of more collaboration among healthcare occupations to provide the highest quality of care for patients.

7.1.4 Recommendation #4: Introduce bias training for all public servants.

This recommendation is particularly important for any public servant in health and social sectors. Public servants in those sectors are more likely to conduct work that perpetuate disparities that affect marginalized groups. Most often, people require additional work to help identify their biases and how they may affect their perception towards certain populations.

This recommendation would include required training for public servants so they can have awareness how things such as the regulatory status can affect their perception of healthcare occupations. This recommendation includes the government providing access for public servants to bias training. Furthermore, bias training would need to cover the concept of professional legitimacy, possibly under the category of class, in the modules. Covering the concept of professional legitimacy and the effects that it has on perception may improve public servants' awareness of such biases and how to mitigate the impacts on their work. Having the awareness of such biases or perceptions is one measure that can be taken on the individual level to identify any perceptions that may unintentionally affect marginalized people, such as those who over represent unregulated occupations in health care.

7.2 Research Implications

The implication of this research is important for two areas of study: occupational regulation in the HHR sector and healthcare decision-making. It highlights the limited attention given to unregulated healthcare occupations, which is a crucial implication of this research. Academic evidence and recommendations often focus on regulated healthcare professionals and

therefore may not be appropriate for unregulated occupations. This lack of attention also perpetuates challenges related to general awareness, attention, and recognition of these roles.

Occupational regulation in the HHR sector is also understudied, specifically in Canada. Greater attention and study are necessary in this area to prevent issues and risks to HHR such as over-professionalization and creating inequities among healthcare workers. This research contributes to the literature on professional legitimacy, occupational regulation, and decision-making in healthcare. It analyzes significant changes resulting from legislation introduced in the past 20 years and is a framework for future research in this area.

7.3 Final Reflections

The HHR sector has faced challenges and pressures even before the COVID-19 pandemic, leading to a shortage of healthcare professionals. Non-professional and unregulated roles have historically been difficult to fill, and these roles do not enjoy the same level of professional legitimacy as their regulated counterparts, despite their important contributions to the delivery of health services. However, the pandemic has brought about a positive change, with healthcare workers, even those in unregulated professions, acquiring recognition for their contributions. The pandemic and attention on healthcare occupations has also paved the way for modernizing and improving how healthcare professions and occupations are regulated. Such changes bring hope that the negative impact of people's perception of professional legitimacy will decrease and that not only regulated healthcare workers are legitimate. Decision-makers play a vital role in HHR decisions and their impact on healthcare workers. It is crucial that all HHR workers be aware of how their perceptions of healthcare occupations can impact their work.

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Appendices

Appendix A – Thematic Matrix

Appendix B – Participant Recruitment Email

Appendix C – Participant Consent Form

Appendix D – Interview Guide

Appendix A – Thematic Matrix

		Appearances of Theme				
Theme	Sub Theme	Literature Review	Case Study #1	Case Study #2	Interviews	Meta Analysis
Occupational Regulation		X	X	X	X	X
	<i>Public Choice Theory</i>	X	X	X	X	X
	<i>Public Interest Theory</i>	X	X	X	X	X
	<i>Purpose of Occupational Regulation</i>	X		X	X	
	<i>Interests of Occupational Regulation</i>	X			X	
	<i>Advantages</i>	X		X	X	
	<i>Disadvantages</i>			X	X	
Culture & Hierarchy		X			X	X
	<i>Authority</i>	X				
	<i>Access to Resources</i>	X	X	X	X	
	<i>Attention to Certain Occupations</i>	X	X	X	X	
	<i>Recognition of Occupations' Roles</i>		X	X	X	
	<i>Over-professionalization</i>				X	
	<i>Workforce Culture</i>				X	X
Government & Decision-Making		X	X	X		X
	<i>Legislative Processes & Constraints</i>	X	X	X	X	
	<i>Role of Decision-makers</i>	X	X	X	X	
	<i>Decision-maker Challenges</i>	X	X	X	X	
	<i>Public Servants</i>	X			X	
	<i>Leadership</i>		X		X	
	<i>Consultation & Collaboration</i>				X	
Professional Legitimacy			X	X	X	X
	<i>Reliance on Professional Legitimacy</i>	X				X
	<i>Terminology of Professionalism</i>				X	
Politics			X	X	X	X
	<i>Influence of Unions and Associations</i>		X	X	X	X
	<i>Power of a Single Profession</i>			X	X	X
	<i>Politics of the Day</i>		X		X	X

Appendix B – Participant Recruitment Email

Hello [PARTICIPANT NAME],

We invite you to participate in a study about **perception of professionalism and impact on health human resource policy**. You are receiving this email because of your leadership role in the B.C. health care system, in a policy or program decision-making role. We would really value your participation and insights on health human resource policy. Your perception and perspectives will offer more significant insights to develop a better understanding of factors that may impact health human resource policy.

Your participation and reporting are confidential. Your peers will not know whether or not you participated in the study. Accepting or declining this invitation to participate will not affect your employment or reputation in any way. Measures have been taken to ensure the strict anonymity of all participants of this study.

Specifically, this study will look at B.C. decision-makers' perceived professional legitimacy of healthcare occupations. Your experiences in the health sector will provide as additional insights that may provide explanations or additional knowledge to support any findings. Please see the attached consent form to participate in the study for your review and for more information on the study. Again, your participation and the data reporting are strictly confidential.

Participation includes a single **interview over telephone or Zoom**. You will be asked a few open-ended questions to prompt your experiences in the healthcare sector as well as your opinions on key factors affecting health human resources policies. You will have access to the questions prior to the interview for your review. The interview will be scheduled for **30 to 45 minutes**.

The research team will summarize the results in a masters dissertation. An executive summary will be available for participants to read as well.

As a current or former leader in health human resources, you play a critical role in the formation of policies and programs that affect the lives of British Columbians. Therefore, we feel your input is critical and will provide a lot of insights.

If you have any questions about participation or the study in general, feel free to contact Julia Bilinski at jbilinski@uvic.ca or XXX-XXX-XXXX.

If you are interested in participating, please fill out the consent form and send it back to this email. You will receive a follow-up email within two to three business days to schedule your interview time. All interviews will be **scheduled during the week of January 30th, 2023**. If you would like to participate in this study, but require a different date please provide possible alternative dates and times.

I look forward to hearing from you!

Thanks for your consideration,

Julia



Julia Bilinski
Master of Public Administration
Student

School of Public Administration
University of Victoria



Perception of Professionalism and Impact on Health Human Resource Policy

You are invited to participate in a study entitled Perception of Professionalism and Impact on Health Human Resource Policy that is being conducted by Robert Lapper and Julia Bilinski.

Julia Bilinski is a graduate student in the department of Human and Social Development, School of Public Administration at the University of Victoria. You may contact her if you have further questions by email at jbilinski@uvic.ca.

As a graduate student, Julia is required to conduct research as part of the requirements for a degree in Public Administration. It is being conducted under the supervision of Robert Lapper. You may contact the supervisor at XXX-XXX-XXXX or rlapper@uvic.ca.

Purpose and Objectives

The purpose of this research project is to study how perceptions of certain occupational groups as “professional”, based on their regulatory status as regulated occupations may affect health care human resource policy This research also aims to identify barriers and opportunities to improve policy and program work in the health human resource sector.

Importance of this Research

Research of this type is important because it will add to the health human resources literature by examining any effects of the perception of professional legitimacy. It will also look at practical implications and opportunities to improve health human resources.

Participants Selection

You are being asked to participate in this study because of your subject matter expertise in health human resource policy and decision-making. We obtained your contact information through the publicly accessible contact information on your organization’s website.

What is involved

If you consent to voluntarily participate in this research, your participation will include participating in a 30-to-45-minute interview over the phone or Zoom. If you agree to participate in this study, you will receive an email with a selection of options to schedule an interview date and time. You will then receive the interview questions a day (24 hours) before your scheduled session. The questions will be approximately six open ended questions about your own perspectives relating to professional legitimacy and health human resources. No personal identifiable informational will be required of you, and your identity will not be linked with your answers.

Inconvenience

Participation in this study may cause some inconvenience to you, including spending up to 30 to 45 minutes of voluntary time to complete the activity.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

The potential benefits of your participation in this research include benefits to participants, society, and the state of knowledge in health care human resource management. It is using a study methodology that reviews existing

literature, and links the findings with the analysis of specific case studies in health human resources policy and regulatory and subject matter expert perspectives. The participants of this study are primarily former decision-makers in health human resource policy, and the results may be beneficial to other public servants by providing an opportunity to reflect on their own perspectives in their work in policy and programs. This study will also be beneficial to society as it will possibly highlight challenges and opportunities to improve health human resource policy and to pay more attention to unregulated health occupations. The health human resource sector is critical to the functionality of the Canadian healthcare system, and any knowledge that helps to address the challenges or highlight opportunities is a positive benefit. Finally, this study will add to the state of knowledge in a field and for health occupations that typically go under researched.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will not be used and will be destroyed. If you do decide to withdraw your consent at any time during the study, please contact Julia Bilinski at jbilinski@uvic.ca.

Anonymity

In terms of protecting your anonymity, no personal identifiable data will be collected during the interview and there will be no way to link your responses with identifiable data. Your anonymity will be protected at every stage of the study. To ensure anonymity, participants will be referred to by their role title in the study results.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by protecting your anonymity throughout the study, and your contact information will be only used in communication purposes. Only the research team will have your contact information. Your information will be destroyed at the end of the study. Only if you opt-in will you receive results and an executive summary of the findings of the study at the end.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways thesis dissertation presentation, internet sharing of thesis, and directly to participants.

Disposal of Data

Data from this study will be disposed of electronic data will be erased upon completion of the study.

Contacts

Individuals that may be contacted regarding this study include the Principal Investigator, Robert Lapper, and Julia Bilinski, Principal Researcher. Their contact information can be found at the top of this form.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix D – Interview Guide

Note: follow up questions may be asked for clarity or more details. The interviewer may also rephrase the question in a different way and follow up on questions.

Questions:

- 1) In what way does the work of public servants (i.e., health policy and program) affect the outcome of health human resources policies?
- 2) In what way does the work of other professional associations and/or unions affect the outcome of health human resources policies?
- 3) What barriers exist in health human resources decision-making, particularly for nonprofessional occupations (i.e., dietary aides, and health care assistants)? How could these barriers be overcome?
- 4) In your experience, how much attention is put on the impact on nonprofessional healthcare occupations?
- 5) In your experience, how much attention is paid to the impact of human resource policy on nonprofessional healthcare occupations?
 - a. In your perspective, why do you think it is so?
- 6) Can you provide any examples (i.e. case studies or experiences) where the perception of professional legitimacy of an occupation influenced the outcome of a policy or program?
- 7) If you had a magic wand, what would be some measures that could be taken to improve health human resource policy and engagement with nonprofessional occupations?
- 8) Do you have any other comment you would like to add about health human resources or your specific experiences that are important to you?