Comparative Critical Policy Analysis of SARS and COVID-19 Policy Responses to PSW Mental Health

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Abstract

This Major Research Project (MRP) assesses policy responses to the impact of COVID-19 on the mental health of Personal Support Workers (PSWs), a segment of frontline workers, in Canada. Specifically, I assess how the experience of the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic is informing policy responses to the mental health challenges experienced by PSWs under COVID-19. Despite the magnitude of the COVID-19 pandemic, with Canada reporting over half a million cases and over 15,000 deaths due to COVID-19 as of December 31st, 2020, this is not the first emergency of its kind in Canada. In 2003, the outbreak of SARS led to close to 500 cases and 44 deaths, resulting in the establishment of the Public Health Agency of Canada. It was then reported that PSWs who provided care to SARS patients experienced poor mental health outcomes - anxiety, occupational burnout, depression, and Post-Traumatic Stress Disorder (PTSD), which persisted two years after the epidemic. COVID-19, substantially more impactful, poses a much greater challenge to the mental health of PSWs. Drawing from a Marxist Feminist perspective – most PSW are low-income and female - this critical comparative policy analysis appraises publicly available documents (e.g., *Learning from SARS – Renewal of Public Health in Canada*) that represent SARS and COVID-19 policy responses. Preliminary findings suggest that policy responses so far have almost entirely missed key lessons learned from the SARS experience. My analysis elaborates on these findings and their implications for practice, policy, and equity.

Keywords: emergency policy, mental health, personal support worker

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Introduction

The COVID-19 pandemic remains an unyielding threat to public health. However, it is becoming increasingly evident that the threat is not isolated to the virus itself but the ways in which the pandemic response has amplified the health inequities entrenched within Canada. Due to the integral role of Canadian frontline healthcare workers within the healthcare system, the primary tool in Canada's COVID-19 defense, this subset of the healthcare workforce has been subjected to a distinct COVID-19 experience and unique risk to their physical and mental health. Despite how vital frontline healthcare workers are in ensuring the well-being of Canadians, it has become seemingly relied upon that frontline healthcare workers sacrifice their mental well-being to provide healthcare to the public.

While adverse mental health outcomes are prevalent across all ages, genders, socioeconomic statuses, and cultures, low-wage and marginalized communities are at the greatest risk for adverse mental health outcomes (Mawani & Gilmour, 2010). The adverse mental health outcomes are easily predictable for low-wage labour forces such as the marginalized groups who comprise Canada's frontline healthcare workers. The mental health of frontline healthcare workers, including nurses and personal support workers (PSWs), have been identified as being particularly vulnerable during public health emergencies (PHE) due to increased exposure to pathogens and workload intensity in the workplace (Canadian Mental Health Association, 2020). Notably, individuals who have pre-existing mental illness are at severe risk of adverse mental health outcomes (Canadian Mental Health Association, 2020). This risk factor elicit concern as a report conducted on behalf of the Canadian Federation of Nurses Union indicated that nurses across healthcare sectors experience adverse mental health outcomes prior to the pandemic including, depression, anxiety, Post Traumatic Stress Disorder (PTSD),

and burnout (Stelnicki & Carleton, 2020). Moreover, the prevalence of adverse mental health outcomes among frontline healthcare workers in Canada is of particular concern in the current context of the COVID-19 due to the pandemic's unrelenting evident severity and longevity. Evidence suggests Canadian FHWs experienced poor mental health outcomes persisting two years following previous PHEs. The outcomes included increased prevalence of anxiety, occupational burnout, depression, and Post Traumatic Stress Disorder (PTSD) largely due to the emergency policy response and the implications on their occupational environment (Maunder et al., 2003; Lancee et al., 2008; Maunder et al., 2006). Although largely unacknowledged within Canadian history, these findings indicate that the emergency policy response and the mental health outcomes they produce have long-term health implications for FHWs.

Although it is a seemingly accepted reality that FHWs are subject to inequities by way of their occupation, previous literature suggests a hierarchy of labour has been established with the Canadian healthcare system wherein workers who provide frontline care for low wages, such as PSWs, are subjected to greater health inequities (Syed, 2020). Despite their utility across the healthcare sector in both public and private spaces, the PSW workforce is unregulated and predominantly comprised of low-wage, racialized female workers who are subjected to exploitative working conditions (Syed, 2020). This inequitable labour relation is entrenched within the Canadian healthcare system and endured by PSWs, leaving them vulnerable to experience greater health inequities that are amplified in the face of a PHE. As PSWs have historically been disregarded and under-researched within the Canadian context, the true extent of adverse mental health outcomes among FHWs facilitated by the policy response to PHEs has yet to be exposed. Exploited and overlooked, the question remains if the previous policy

responses to PHEs in Canada considered PSWs or included the experience of PSWs in the chosen "lessons learned" from PHEs experience.

Statement of Problem & Scope of Research

Statement of Problem

The present research aims to critically assess if and how the policy response to the 2003 Canadian SARS epidemic and the following FHWs' mental health outcomes have informed policy responses to the COVID-19 pandemic. While an examination of the Canadian policy response to all 21st century PHEs is preferable, such an undertaking does not adhere to the scope of the major research project (MRP). The COVID-19 pandemic was chosen for this study due to its unprecedented domestic and global impact on public health and public health systems. Subsequently, the SARS epidemic was selected as a comparator to the policy response of COVID-19 due to its historical impact on the Canadian policy landscape. Of particular interest are the ways in which the policy response to SARS may have informed the COVID-19 mental health policy considerations or emergency mandates that have implications for frontline healthcare workers, specifically PSWs. It is anticipated that experience of SARS would have provided the Canadian and Ontario governments with valuable insight into preparing and supporting FHWs, their primary tool to combat future PHE. However, evidence indicates that minimal policy effort was exerted to protect the mental health of FHWs within the first calendar year of COVID-19, in turn subjecting FHWs, especially PSWs, to unnecessary mental health risks and preventable mental health distress.

The present research employed a Marxist Feminist approach in its examination, as informed by Foley (2019), Gimenez (2001; 2005), and Berberoglu (1994). This theoretical orientation is aligned with the goal to examine the broader social, political, and economic context

of policy responses and distributions of power that may disproportionately impact the mental health of PSWs. Furthermore, the Marxist Feminist framework is well suited to understand how race and gender combine to influence the status of PSWs under the social relations of capitalism. Additionally, the present research conducted a critical comparative policy analysis between the emergency policies implemented in Canada as a response to the 2003 SARS outbreak and the present COVID-19 pandemic to understand how the mental health of FHWs has been problematized and prioritized within the federal/provincial/territorial (F/P/T) policy response to PHEs. The critical comparative policy analysis structure enabled an examination of the policies relevant to the mental health outcomes of PSWs, such as mental health supports, access to personal protective equipment (PPE), financial security, the stability of work directives, or staffing/understaffing. It is posited that this line of inquiry will provide valuable insight into the experience and needs of frontline healthcare workers during public health emergencies such as COVID-19.

Scope of Research

While the primary population of interest are FHWs, the present MRP focuses on PSWs, an essential subset of the healthcare workforce. For the current research, the term PSWs refers to healthcare workers who provide consistent personal care and assistance to patients and or clients, including but not limited to PSWs, Health Care Aides, Care Aides, and Community Development Service Members. Focusing on PSWs provides unique insight into the experience of FHWs as PSWs are employed across both public and private care sectors settings, including hospitals and long-term care. Additionally, under a system of capitalist social relations these FHWs are more likely to experience mental health inequity by way of their gender and race

identities, demonstrated through the exploitative labour practices. Although the health inequities experienced by FHWs extend beyond mental health, the present research is focused on this subset of health as it is mainly under-researched for the population of interest.

Additionally, while the awareness and support of mental health needs of Canadians have increased, meaningful policies that address the mental health inequities produced by working conditions have yet to be implemented. Moreover, these health inequities are subject to increase during and following PHEs (Lancee et al., 2008; Maunder et al., 2006; Maunder et al., 2003), a critical contextual parameter of the present research. Though PHEs may refer to a wide range of circumstances that threaten public health, including environmental disasters or bioterrorism, the current research is concerned with human-based disease outbreaks of coronavirus epidemics and pandemics. The present study focuses on the 2003 SARS epidemic and COVID-19 pandemic within Canada. The PHEs were selected due to their historical impact on Canada within the 21st century (Rae & Zeng, 2020). They can provide a unique opportunity to analyze the ways in which FHWs, specifically PSWs, have been and continue to be considered within the emergency policy. Finally, due to the particular impact of the 2003 SARS epidemic, the policies of interest in both the 2003 SARS epidemic and the present COVID-19 pandemic are restricted to those within the jurisdiction of the Ontario Provincial government and the Canadian Federal government to ensure a relevant comparison.

Background

Healthcare in Canada

Canada's provision of healthcare relies on the collaboration of federal agencies, including the Health Canada, Public Health Agency of Canada (PHAC), Department of Finance, and Parliament of Canada (Health Canada, 2019). While the provinces are mandated to administer

and deliver healthcare services, of particular interest to the present research is Ontario's provision of healthcare services. The Ontario Ministry of Health and Long-Term Care is responsible for the policies and administering of healthcare services throughout the province (Health Canada, 2019). Ontario operates under the *Health Protection and Promotion Act* and the *Ontario Public Health Standards* (PHAC, 2016). Additionally, public health concerns, including public health emergencies, led to the development of public health boards in the local jurisdictions (Bryant, 2016).

While Canada boasts a universal healthcare system, the commodification of healthcare services has still persevered. Specifically, the provision of dental care and mental healthcare is not protected under the *Constitution Act* or the *Canada Health Act*. While the *Constitution Act* stipulates the government is responsible for institutions for the mentally ill, additional mental healthcare is not guaranteed (Dunlop, 2015). Canada's universal healthcare system favours conceptualizing health in a traditional biomedical model, focusing on the physical experience, and characterizing health as the absence of disease. In practice, this leads to an emphasis on symptomatology and the treatment of disease at a micro-level. Outside of this framework, health is more aptly defined as physical, mental, and social well-being, not simply the absence of disease i.e., the biopsychosocial model (World Health Organization, 1995). By this definition, mental health is an integral extension of health, and comparable mental health outcomes are unevenly distributed in Canada. Specifically, low-income Canadians are up to four times more likely to experience negative mental health outcomes compared to high-income populations (Mawani and Gilmour, 2010). Additionally, women present with higher rates of mood-related mental illness (Pearson, Janz & Ali, 2013) and attempt suicide four times more compared to men (Statistics Canada, 2017). While mental illness accounts for 10% of the burden of disease, it

merely receives 7% of healthcare spending in Ontario (Institute of Health Metrics and Evaluation, 2015). This financial neglect results in the underfunding of mental healthcare by $1.5 billion in Ontario alone (Brien et al., 2015). Additionally, the Mental Health Commission of Canada (2012) indicates the need to increase government spending on mental healthcare by 9% across Canada. Ironically, bridging the public experience of mental health neglect and the under resourced healthcare system are the FHW's who are tasked with the provision of healthcare while enduring the seemingly occupational hazard of adverse mental health outcomes.

Mental Health of Frontline Healthcare Workers

Unsurprisingly the predominantly feminized, racialized, and low-wage professions held by FHWs are subjected to adverse mental health outcomes in the face of PHE. Frontline healthcare workers across the globe experience have documented increased anxiety (Chirico et al., 2020; Cui et al., 2021; De Kock et al., 2021; Gómez-Salgado et al., 2020; Nelson et al., 2020; Hickey, 2014; Pearce, 2020; Rizos et al., 2020; Sanghera et al., 2020; Stelnicki & Carleton, 2020; Stuijfzand et al., 2020; Vera San Juan et al., 2020; Wise et al., 2020), increased depression (Chirico et al., 2020; Cui et al., 2021; De Kock et al., 2021; Hickey, 2014; Gómez-Salgado et al., 2020; Nelson et al., 2020; Pearce, 2020; Rizos et al., 2020; Sanghera et al., 2020; Stelnicki & Carleton, 2020; Stuijfzand et al., 2020; Vera San Juan et al., 2020; Wise et al., 2020), suffered from PTSD (Chirico et al., 2020; Cui et al., 2021; Gómez-Salgado et al., 2020; Stelnicki & Carleton, 2020; Nelson et al., 2020; Pearce, 2020; Sanghera et al., 2020; Stuijfzand et al., 2020; Tracey et al., 2020; Vera San Juan et al., 2020), and even suicide ideation following a PHE (Chirico et al., 2020; Greenberg et al., 2020; Wise et al., 2020). This trend was evident in Canada following the 2003 SARS outbreak wherein active frontline healthcare workers who were

exposed to SARS patients experienced event related anxiety, PTSD, and burnout (Maunder et al., 2003) that persisted for two years (Maunder et al., 2006; Lancee et al., 2008). Over a year has passed since frontline healthcare workers were called to action as Canada's primary defence against the persistent COVID-19 pandemic and policy action should seek to provide meaningful support to those who continue to endure the mental health risk and adverse mental health outcomes associated with providing healthcare in Canada.

Evidence in this field suggests that the adverse mental health outcomes experienced by frontline healthcare workers are reduced by their individual actions within their workplace such as increased collaboration with colleagues (Chirico et al., 2020; Gómez-Salgado et al., 2020; Greenberg et al., 2020;) or regularly reviewing safety procedures (Cui et al., 2021; Pearce, 2020). However, more pertinent to the present research are the system level solutions. System level solutions are present throughout the literature which by way of comprehensive documentation indicate that the adverse mental health outcomes experienced by FHWs may be reduced or avoidable entirely. One notable intervention includes the provision of fully funded mental health supports accessible to all frontline healthcare workers (Chirico et al., 2020; Gómez-Salgado et al., 2020; Greenberg et al., 2020; Nelson et al., 2020; Pearce, 2020; Sanghera et al., 2020; Stuijfzand et al., 2020; Tracey et al., 2020; Vera San Juan et al., 2020). Other identified interventions include practice-oriented solutions such as mandated healthcare team debriefs (Gómez-Salgado et al., 2020; Greenberg et al., 2020; Nelson et al., 2020; Tracey et al., 2020) or streamlining public health directives (Gómez-Salgado et al., 2020; Greenberg et al., 2020; Nelson et al., 2020; Pearce, 2020; Vera San Juan et al., 2020).

Despite the various proposed solutions to the mental health risk faced by frontline healthcare workers, the solutions utility within Canada has yet to be explored. More importantly,

the specific system level challenges which may be faced by frontline healthcare workers within Ontario have yet to be comprehensively documented. This lack of thorough examination of the issue indicates that Canada's emergency policy response remains inadequately informed.

Public Health Emergencies & Canadian Policy

Canada's policy response to PHEs in the 21st century is tangentially committed to global, national, and local frameworks relevant to the present research, including the International Health Regulations (IHR), the World Health Organizations Pandemic Influenza Risk Management (PIRM), North American Plan for Animal and Pandemic Influenza, the Canadian Pandemic Influenza Preparedness, Ontario Health Plan for a Pandemic Influenza (PHAC, 2020). The IHR is a legal framework established in 2005 that outlines the rights and international responsibilities of 196 countries when handling public health emergencies (World Health Organization, 2005). The IHR predominantly defines legal obligations regarding the detection, reporting, and response to Public Health Emergencies, including criteria for qualifying a public health event as a Public Health emergency, surveillance frameworks, and government response timelines (World Health Organization, 2005).

In addition to the IHR, the World Health Organization provides a global framework for identifying and responding to Public Health Emergencies established in 2009 and amended in 2013 entitled *Pandemic Influenza Risk Management* (World Health Organization, 2019). The document emphasizes a "flexible" global response to public health emergencies wherein a nation's emergency planning, response, and ethical considerations are independent of the nation's capacity and needs (World Health Organization, 2019). Within the continent of North America, Canada, the USA, and Mexico have committed to the North American Plan for Animal

and Pandemic Influenza 2012 (NAPAPI) in replacement of the *North American Plan for Avian and Pandemic Influenza* (Public Safety Canada, 2015). A continent specific adoption of the IHR, the NAPAPI is a collaborative "health security" framework for preparing, reporting, and responding to public Health Emergencies (Public Safety Canada, 2018). The NAPAPI outlines modes for detecting, monitoring, and managing public health emergencies through facilitating communication and increasing infrastructure across North America with the goal of mitigating the "social and economic impact" of public health Emergencies (Public Safety Canada, 2018).

While Canada remains publicly committed to the IHR, the World Health Organizations PIRM, and the NAPAPI, Canada has established additional frameworks to guide the nation's policy response to public health emergencies at F/P/T levels. The Canadian Pandemic Influenza Preparedness: Planning Guidance for the Health Sector (CPIP) is an evergreen strategy designed to guide a collaborative federal, provincial, and territorial response to public health emergencies and first established in 2004, and underwent amendments in 2006, 2012, and 2014 (PHAC, 2019). The CPIP primarily outlines jurisdictional responsibilities and approaches to risk management; however, the CPIP encourages a coordinated response, emphasizing the need for provincial/territorial level public health emergency planning reflective of the needs of the local population (PHAC, 2019). The province of Ontario established the Ontario Health Plan for a Pandemic Influenza (OHPIP) in 2013 as a framework for planning and anticipating response activities to public health emergencies (Government of Ontario, Ministry of Health and Long-Term Care, 2013). Adhering to the CPIP, the OHPIP aims to minimize the health and social impact of the public health emergency through infection prevention and control measures, immunization programs, timely detection, and intervention protocols (Government of Ontario, Ministry of Health and Long-Term Care, 2013).

Canada recognizes five distinct emergencies that fall under the jurisdiction of the federal government: national emergencies, public welfare emergencies, public order emergencies, international emergencies, and war emergencies. Recent PHEs within the Canadian context, includes SARS, H1N1, Ebola virus, Zika virus, and the present COVID-19 pandemic. The Emergencies Act enables the Canadian government to respond to emergencies by taking "special temporary measures to ensure safety and security during national emergencies and to amend other Acts". Functionally the Emergencies Act affords the government the power to reallocate resources and expedite emergency policy intervention (Emergencies Act, 1985). The following sections detail the PHE's of interest to the present research as well as their significance to Canada.

Severe Acute Respiratory Syndrome & Canada

SARS-CoV, or severe acute respiratory syndrome (SARS), is a coronavirus infectious disease that causes mild to severe respiratory infection and flu-like symptoms (Rae & Zeng, 2020). In 2003, Canada experienced an outbreak of SARS that lasted over a six-month period between February and July. Precise documentation of total cases and fatalities due to SARS were not recorded, presumably due to a lack of testing and a non-existent health record sharing agreement between the Federal and Provincial governments. However, estimates 438 total cases and 44 deaths due to an outbreak of SARS (Health Canada, 2004). The majority of cases and all fatalities being reported from Toronto, Ontario (Health Canada, 2004). In 2003, Canada lacked the independent ability to investigate and verify the extent of threat SARS posed to the public health of Canadians, increasing Canada's reliance on the World Health Organization regarding the status of SARS internationally (Health Canada, 2003).

Notably, the SARS epidemic provoked the government of Canada to establish the National Advisory Committee on SARS and Public Health, that was designed to provide third-party assessment of the public health efforts and the implications for infectious disease control in Canada (Health Canada, 2003). The report, entitled Learning from SARS: Renewal of Public Health Canada, acknowledges that Canada was immensely ill-prepared for a "true pandemic" and called for a paradigmatic shift in public health (Health Canada, 2003). The strain SARS placed on Canada's economy, the health of Canadians, and the mental health of frontline healthcare workers is often considered the reason for the establishment of the PHAC in 2004 (Rae & Zeng, 2020). The PHAC was designed with the explicit intent to aid the Government of Canada's efforts to promote health, reduce disease, and "respond to public health emergencies and infectious disease outbreak" (Government of Canada, 2017). Moreover, the PHAC Act provides a legislative basis for the PHAC and the Chief Public Health Officer to collaborate with various levels of government to address public health concerns (Government of Canada, 2017).

The mental health issues within Canada's healthcare system and the unique mental health risk FHWs are subject to is only exacerbated in the face of public health emergencies. The 2003 outbreak of SARS in Canada lasted six-months and primarily affected the densely populated regions of Ontario and British Colombia (Rae & Zeng, 2020). The outbreak provoked the Ontario government to declare a state of emergency (Rae & Zeng, 2020). Although in today's context this seems negligible, the impact SARS had on the public and healthcare workforce's mental health was not. The frontline healthcare workers who provided care to SARS patients experienced negative mental health outcomes, including anxiety and PTSD (Maunder, 2003). This result was associated with the occupational environment, which saw frequent changes in policy directives, restricted work mobility, and caring for infected colleagues (Maunder et al.,

2003). More alarmingly, during the epidemic it was reported that FHCWs, who provided care to SARS patients, experienced poor mental health outcomes, including increased prevalence of anxiety, occupational burnout, depression and PTSD due to the emergency policy response to SARS and the occupational environment, including frequent changes in policy directives (Maunder et al., 2003). Further, these outcomes persisted two-years after the SARS epidemic (Maunder et al., 2003; Lancee et al., 2008; Maunder et al., 2006) indicating long-term health implications for FHCWs. The blatant lack of consideration for the mental health of frontline healthcare workers in Canada's response to the SARS outbreak is a reflection of Canada's approach to healthcare's inability to account for the broader influences on health. Canada was ultimately politically, economically, and socially unprepared for the SARS outbreak, a reality which was reflected in the aftermath of the outbreak, leaving the question of how this experience influenced the experience of COVID-19 in Canada.

COVID-19 & Canada

COVID-19, also referred to as SARS-CoV-2, is a coronavirus infectious disease that exhibits similar symptomology and transmission to SARS, including mild to severe respiratory infection and flu-like symptoms (Caldaria et al., 2020). The first case of COVID-19 in Canada was documented on January 25th, 2020. By the end of the calendar year, December 31st, 2020, Canada reported 565,506 total cases and 15,378 deaths due to COVID-19 (Government of Canada, 2020). As of October 26th, 2021, 1,702,587 of total cases and 28,805 deaths as a result of COVID-19 have been reported in Canada with no tangible end to COVID-19 in sight (Government of Canada, 2021). Vaccination for COVID-19 began on December 13th, 2020 (PHAC, 2021). At present, five vaccines are approved for administration throughout Canada,

including the two-dose mRNA vaccines, Pfizer-BioNTech and Moderna, the two-dose viral vector-based vaccines AstraZeneca and COVISHIELD, and the one dose viral vector-based vaccine Janssen (PHAC, 2021). The COVID-19 pandemic continues to impress itself upon Canada's political, economic, and psychosocial landscapes as the threat of variants loom, including Alpha (B1.1.7), Gamma (P.1), Beta (B.1.351), and Delta (B.1.617.2) loom. As the COVID-19 continues to evolve and COVID-19's long-term significance written into history, it is evident that COVID-19 is unparalleled to all previous PHE's experienced by Canada within the 21st century.

Interim reports indicate that the mental health of FHWs is suffering during the COVID-19 pandemic. A crowdsourced survey hosted by Statistics Canada (2021), in collaboration with Health Canada, CIHI, and PHAC, throughout November and December of 2020 reviewed the experiences of 18,000 healthcare workers across Canada. Approximately 70% of healthcare workers reported a significant decline in their mental health, and 56% reported an increase in overall stress since the start of the pandemic (Statistics Canada, 2021). Two distinct themes were present within the results, exposure to COVID-19 and access to PPE. Similar to the findings following the SARS epidemic, FHWs who provided care to patients or clients with suspected or confirmed cases of COVID-19 reported worse mental health in comparison to those who did not (Statistics Canada, 2021). Further, 77% of respondents reported a significant decline in mental health compared to pre-pandemic, while 62% of FHWs who had yet to provide care to COVID-19 patients or clients reported a decline in mental health compared to pre-pandemic experience (Statistics Canada, 2021). In addition to exposure, a FHWs access to PPE due to inventory control or ongoing shortages impacted the mental health of the workforce. FHWs reported limits on PPE supply and use wherein 31% had to extend use of PPE beyond best practice guidelines,

18% were required to reuse their PPE, and 11% had to supply their own (Statistics Canada, 2021). Unsurprisingly, those without PPE restrictions reported better mental health in comparison to FHWs whose access to PPE was restricted (Statistics Canada, 2021). In addition to the increase of mental distress brought on by accessible PPE, preliminary survey results indicated that Canadian FHWs had an elevated COVID-19 infection rate of 9.5%. This infection rate is an accomplishment by comparison to the preliminary 19.5% infection rate wherein 24 FHWs died as of January 12th, 2021 (CIHI, 2021). Moreover, despite advocating for better protections, FHWs report an overwhelming feeling of abandonment and a sense of violation by the government's inaction, anxiety over the risk of infecting loved ones, and overall exhaustion due to understaffing and increased workload (Brophy et al., 2021).

Personal Support Workers and COVID-19

PSW's are an essential frontline workforce who provide healthcare services under numerous job titles. Further they assume positions across the healthcare sector in both public, private, and mixed funding settings, including home care, long-term care facilities, adult day programs, community support services, supportive housing, group homes, private homes, hospitals, and educational facilities (Avtar, 2009; 2021). While a PSW's role is predominantly dictated by the setting in which they are employed, PSW's are consistently on the frontlines of the healthcare workforce providing personalized and essential care to patients or clients regardless of setting (Avtar, 2021). The PSW labour force is characterized as low-income and is becoming increasingly feminized and racialized across Canada (Syed, 2020; Dube, 2020; Turcotte & Savage, 2020). Over one-third of individuals employed in patients support services are immigrants, wherein women make up 86% of the immigrant workers and 87% of the non-

immigrant workers (Turcotte & Savage, 2020). Unfortunately, their low-income, feminized, and racialized status is placing the workforce amongst the precariat class leading to exploitative working conditions with low wages, limited benefits, no sick leave, and failing work standards (Syed, 2020; Dube, 2020).

The PSW labour force remains in a unique position within the Canadian healthcare system, presumably due to their relation to government regulation. Unlike other healthcare professions such as doctors, naturopaths, or nurses, PSWs are presently an unregulated subset of the healthcare workforce (Avtar, 2021). Although PSWs are required to abide by the policies enforced within their employment setting or provincial legislation, PSWs are without a consistent job title, governing body, standards of practice, or standardized training within the public or private sector. Additionally, despite providing healthcare services often covered through Canada's universal healthcare system, PSWs are hired as non-government workers and provided to patients or clients through external organizations (Avtar, 2021). Moreover, the lack of regulation leaves PSWs vulnerable to the exploitative labour relations they are subject to. PSWs are left isolated in the workforce and without a unionized voice to advocate for them as a collective within the field of healthcare.

Within the province of Ontario, the lack of labour regulation has not been without contestation. Relevant debates regarding the status of PSWs within the Ontario healthcare system date back to 2005, wherein George Smitherman, Minister of the Ontario Ministry of Health and Long-Term Care for the liberal government, submitted the profession for official review to the Health Professions Regulatory Advisory Council (HPRAC) (HPRAC, 2006). Upon review, the HPRAC ruled against the registration and regulation of PSWs under the Regulated Health Professions Act, 1991, as PSWs "do not meet the requirements for regulation" (HPRAC, 2006).

In lieu of regulation, Community Care Access Centre (CCAC) and the Victorian Order of Nurses and Saint Elizabeth Health Care became the predominant suppliers of PSWs within Ontario. Due to their integral role within the Ontario healthcare system, an audit of the CCAC was performed by the request of the Auditor General. The audit identified cost to clients varied drastically depending on the region with approximately 14,000 differing contract rates across 94 service categories and increases to executive officer spending and salaries over 27% (CBC, 2015). In response to the state of the labour relations, the Self-Directed Personal Support Services Ontario (SDPSSO) was established in 2017 the under liberal government with the intent to regulate homecare for Ontarians, yet, had no implication for PSWs working in hospital or long-term care settings (Avtar, 2021). However, the Ontario Ministry of Health and Long-Term Care under the newly elected conservative government announced the retirement of the SDPSSO program in 2018 due to administrative burdens and directed patients and clients seeking PSW services to Local Health Integration Networks, the provinces regional health authorities (Ministry of Health and Long-Term Care, 2018). It is important to note that in 2021, Bill 283 was announced by the Ontario Minister of Health, which includes the Health and Supportive Care Providers Oversight Authority Act, wherein regulation of PSWs is to be established (Ontario Minister of Health, 2021). Further review of the Health and Supportive Care Providers Oversight Authority Act is included within the *Findings* of the present MRP.

It is evident that FHWs are an essential force necessary to combat PHEs such as SARS and COVID-19. However, despite being the primary feature of emergency response, the FHWs are utilized as an impervious tool and not a part of the population requiring protections. The exploitative labour relations pre-date the PHEs of interest; however, in the midst of PHEs such conditions are deepened and made more evident. The precarious and exploitative working

environment has aided the aforementioned adverse mental health outcome endured by PSWs. Furthermore, without appropriate oversight, Ontario became increasingly ill-equipped to provide health support services in the face of a PSW shortage which was horrifically brought to the publics' attention when the COVID-19 pandemic overwhelmed the Ontario healthcare system. Specifically, the Ontario Health Coalition advocacy group highlighted that the pre-existing chronic staffing shortages was a significant contributor to the alarming working conditions and burnout amongst PSWs (CBC, 2020). Moreover, the COVID-19 pandemic first made a devastating impact on Ontario long-term care residents and workers. By April 7th, 2020, 58 outbreaks within long-term care homes were active across Ontario alone, wherein 42% of cases were among staff (Pinto et al., 2020). Additionally, interim reviews indicate that PSWs overrepresented the FHWs who died due to COVID-19 (Dube, 2020). The living and working conditions within Ontario long-term care settings during COVID-19 solicited military intervention; a response explored further in the findings of the present MRP.

Similar to other inequities, the pattern of exploitation endured by PSW's is subject to exacerbation during the ongoing COVID-19 pandemic, in spite of the observed FHW mental health outcomes following the SARS epidemic. Moreover, as PSW's mental health is relatively under-researched and this subset of FHW's remain traditionally unprioritized in meaningful policy support, Canada's emergency policy response to COVID-19 stands to overlook PSWs and their mental health needs. The present MRP seeks to identify if and how the emergency policy response to the 2003 SARS outbreak informed the federal government of Canada and the province of Ontario policy response to COVID-19. It is anticipated that despite the experience of SARS and its potential to provide F/P/T governments with valuable mental health insight into preparing and supporting FHWs, minimal policy effort would have been exerted to protect the

mental health of FHWs during COVID-19. Furthermore, this oversight in turn has subjected FHWs, especially PSWs, to unnecessary mental health risk and preventable mental health distress.

Theoretical Considerations

A Marxist Feminist perspective adapted from the work of Foley (2019), Gimenez (2001; 2005), and Berberoglu (1994) was used to inform the investigation of the current research topic. As previously noted, the population of focus are PSWs, who are also predominantly low-wage, racialized women (Syed, 2020), characteristics that exemplify a social location intersecting on race, gender, and class. A Marxist perspective is most fitting as the inequities explored in the present research are fundamentally embedded in the relations of production, a fundamental principle of Marxist analysis. Moreover, the Marxist Feminist perspective provides a mode to identify and understand inequity through exploring the capitalist context and socio-economic system that maintains and produces inequity.

Specifically informed by Foley (2019), the present research aimed to emulate the Marxist Feminist framework by moving class beyond an identity prescribed to an individual or group and viewing class, such as the predominantly low-income status of PSWs, as a relationship that produces and maintains inequitable social relations (Foley, 2019). Similarly, Gimenez (2001) showcases that both racial and gender oppression and, thereby, health inequities cannot be isolated from the act of exploitative class and labour relations. Further, Gimenez (2005) illustrates that the oppression of marginalized groups, including women and black, indigenous, people of colour (BIPOC) community members, is visible and observable through the social formation of labour relations such as those experienced by PSWs. Additionally, Gimenez (2005) demonstrates the means of production and reproduction of the aforementioned social formations

in capitalist society are dictated by the established economic structures, a relevant concern for the present analysis of the development of emergency mental health policy considerations within the context of Canadian private and public healthcare institutions. Similarly, Berberoglu (1994) highlights that while class divisions are a product of maintaining gender and race inequities, it does so for more significant private profit. Moreover, although populations can reduce the level of inequity by becoming a member of the *ruling class*, women and minority workers are subject to greater oppression through class and labour divisions, and as such are subject to greater inequities (Berberoglu, 1994), a reality that is only subject to inflation strained further within the context of PHEs.

Methodological Considerations

Document Analysis

Foundational to the present study is the notion that qualitative data, such as policy documents, are "social facts" reflective of social relations and distributions of power (Bowen, 2009). Consequently, the present research's methodology upholds an intrinsic appreciation for all aspects of the qualitative data (i.e., policy documents). This to say that a documents narrative, as well as its word choice, and organization convey meaning essential to the understanding of the document and broader social relations (Bowen, 2009). As such, all the components of the selected data were given equal value throughout the analysis detailed below.

Critical Comparative Policy Analysis

A critical comparative policy analysis framework adapted from the work of Codd (1988), Diem et al. (2014), and Bacchi (2016) guided the examination of the emergency policy response to both the 2003 SARS epidemic and the present COVID-19 pandemic. The primary goal of the

present research is to analyze the policy wherein an examination of the values, assumptions, and ideologies are conducted to determine how, if at all, the mental health of FHWs, specifically PSWs, are considered. Specifically drawing from Codd (1988), my analysis aimed to go beyond the explicit intentions stated within the policies by deconstructing the language used within the policy to identify the hegemonic narratives that sustain the inequities. Additionally, Codd's (1988) discourse-centred approach encourages the pertinent examination of how political power and ideological conventions are legitimized through language and preserved in the policies. Moreover, Codd (1988) provides a practical orientation for examining the explicit content of a policy. While Codd (1988) provides a high-level approach to critically evaluating policy through the language employed, Diem et al. (2014) provides a complementary insight into the policy analysis process. Like Codd (1988), Diem et al. (2014) acknowledged the importance of recognizing the policy context and social complexities. Diem et al. (2014) establish that identifying what is centred within the policy but of equal importance is absent from the policies. By raising critical questions about inequities and power distributions, one can determine who has or is being given a voice within the policy.

Moreover, Diem et al. (2014) provides a practical extension for critical policy analysis by identifying five distinct stages of critical policy analysis that guides the present research; including (1) *interrogation*, examining the policy claims in tandem with the policy reality, (2) *reflection*, investigating the past, present, and future development of the policy, (3) *structure*, analyze how what is centred within the policy re-establishes a distribution of power and resources producing inequity, (4) *context*, explore the broader contextual impact of the policy, (5) *progress*, identify meaningful critiques that "promote agency, resistance, advocacy, and praxis" (Diem et al., 2014).

Furthermore, Bacchi (2012, 2016) informed the approach of identifying the problems beyond what and how they have been problematized within the policy, i.e., the *What Is the Problem Represented to Be* (WPR) approach. The WPR framework provides a tangible means to understand the assumptions and conceptualizations of a problem embedded within policy. Expressly, the WPR acknowledges active features of a policy issue wherein the problematization of the issue is a reflection of the governments' acknowledgement and public response to the issue and thus, how the representation of the problem within policy drives what the desirable or possible solution is (Bacchi, 2012; 2016).

Thematic Analysis

In addition to the comparative critical policy analysis approach detailed above, the present study pulled inspiration from the methodology employed by Yousefi and Chaufan (2021). As such the present study's methodology drew from Braun and Clarke's (2006) thematic analysis approach. Complementary to the aforementioned approach, the present study ensured that data was reviewed to the point of familiarity, closely examined to identify the construction of PSW mental health narratives throughout the documents, identified themes were documented alongside illustrative quotations, and then the data and findings were holistically reviewed with the aim of interpretatin of the documents utility in reproducing or challenging distributions of power (Braun & Clarke, 2006).

Critical Discourse Analysis

Further informing the present research methodology is Fairclough's (1993; 2013) work regarding the Critical Discourse Analysis approach. Fairclough's assertion that the dominant

narrative evident within key texts (i.e., policy documents) are produced to the benefit of those in power served as a central inspiration to the present study. While an exact replication of Fairclough's (2013) eleven-step method of inquiry was not employed in the present research, the present study's analysis aimed to identify the narratives lobbied for within PHE policy response. In doing so, the aim was to further determine what forms of the capitalist structures and inequitable social relations are being legitimized and reproduced through policy under capitalism.

Policy Analysis Probes

The following are the policy analysis probes to engage the selected policy documents in the present study.

1. What is the political, social, development context of the policies? How is it reflected within the policy rhetoric?
2. What is the problem represented to be? Who and what is centred in the policy?
3. What are the distributions of power? How are the distributions being legitimized and maintained through the language within the policy?
4. How does the SARS emergency policy response compare to the COVID-19 emergency policy response? How is the mental health of PSWs prioritized throughout time?

Source of Data

To represent the policy response to the 2003 SARS epidemic, a summary report was chosen entitled *Learning from SARS – Renewal of Public Health in Canada* by the National Advisory Committee on SARS and Public Health (NACSPH) (Health Canada, 2003). This

document was selected as it provides detailed documentation of the policy interventions and a comprehensive third-party assessment of the emergency policies employed in response to SARS. Additionally, the report outlines public health reform recommendations that may, in turn, provide illustrative insight into the priorities upheld in current policy responses to public health emergencies. While the document does include the policy interventions employed across Canada and therefore outside of the scope of this study, the report focuses on Ontario as the SARS outbreak was predominantly localized to this region. It is important to note that while this source of data is comprehensive, it is limited to the scope outlined by the NACSPH (Health Canada, 2003).

Contrasting SARS, the COVID-19 pandemic is presently ongoing, and as such, a comparable summary report to that of the selected data for the 2003 SARS epidemic has yet to be published. Consequently, the *COVID-19 Intervention Scan* by the Canadian Institute for Health Information (CIHI) was selected to represent the policy response to the developing COVID-19 pandemic. The intervention scan was chosen as it features Canada's policy response across jurisdictions, including federal, provincial, or territorial governments dating back to May 5th, 2020. Additionally, the scan details key information about COVID-19 policy interventions relevant to the research goal, including six distinct categories: case finding and management, openings and closures, physical distancing, health workforce capacity, health services, and travel restrictions. Similar to the value of the selected SARS data, the scan is also limited to the policies collected by CIHI, thereby restricted to the scope outlined by CIHI. Finally, while the *Learning from SARS – Renewal of Public Health in Canada* report by NACSPH was reviewed and analyzed in its entirety, the relevant policies within *COVID-19 Intervention Scan* by CIHI were

selected for review and analysis. Therefore, the distinct selection and extraction method of the relevant SARS and COVID-19 policies is detailed in the following sections of the methodology.

Inclusion & Exclusion Criteria

Policies determined to be associated with mental health interventions and PSWs were analyzed. Mental health policies were defined as policies that explicitly used the key terms or phrases "mental health," "psychosocial," and "psychological" indicating a total or partial focus on the topic. These policies include mental health interventions announced alongside or a part of more extensive emergency directives that meet the criteria above. Therefore, any policies that did not explicitly identify as mental health-related were excluded. Additionally, only mental health policies that pertained to new or amended intervention strategies implemented as a result of COVID-19 were included. Therefore, mental health policies that concerned mental health interventions that predated the PHE and did not alter their operation were excluded, such as open/closing directives.

In addition to the mental health policies, policies related to PSWs and policies that impact the operation of the profession were of interest to the present research. These were operationalized as policies that explicitly included the key terms or phrases "Personal Support Worker" as well as job title variations including "PSW," "Health Care Aide," "Care Aide," "Home Support Worker," "Personal Attendant," and "Community Development Service Member". Upon full document review, the job title "Patient Service Aide" was identified and included in the findings due to its probable reference to labour traditionally conducted by PSWs. Further, in order to obtain comprehensive insight into the topic, policies that pertain to the healthcare settings or working conditions were included by way of explicit mention of

"Frontline," "Frontline Healthcare Worker," "Long-Term Care". All relevant policy information was then summarized within a table (*see Table 2*). Finally, only policies within the jurisdiction of the Ontario Provincial government and the Canadian Federal government were included in the analysis of the present research.

Data Selection, Extraction, & Analysis Phases

The following section details the selection, extraction, and analysis phases for the policy response to SARS and COVID-19 (*see Figure 1*). First, the SARS document, *Learning from SARS – Renewal of Public Health in Canada*, was thoroughly reviewed. Particular attention was given to the *Executive Summary*, the final chapter entitled *Learning from SARS: Renewal of Public Health in Canada* and the section of the report that explicitly uses the inclusion criteria. Upon full text review using the probes as well as broad themes were documented, including an illustrative quote and location index, to enable an initial high-level critical analysis of the text (*see Table 1)*. Next, to ensure continuity with the COVID-19 policy selection and extraction method, all statements aligned with the inclusion criteria within the document were identified using a key term search strategy, and all relevant results were highlighted for review. Therefore, all mental health statements identified through searching "mental health," "psychosocial," and "psychological" were highlighted within the document. Similarly, all PSW statements, identified through searching "Personal Support Worker," "PSW," "Health Care Aide," "Care Aide," "Home Support Worker," "Personal Attendant," "Community Development Service Member," "Patient Service Aide," "Frontline," "Frontline Healthcare Worker," and "Long-term Care" were highlighted. Key information pertaining to the selected policies were subsequently documented, including term, frequency of the term, location index, and key context information (*see Table 2*).

The topic specific selection was then reviewed using the probes and the WPR as well as themes were documented, including an illustrative quote and location index, to enable subsequent critical analysis of the policy (*see Table 3)*.

A similar process was used to engage in the *COVID-19 Intervention Scan* by CIHI; however, due to the excel format of the document and continuing development of COVID-19 thereby the document the following steps were employed. To begin, the *COVID-19 Intervention Scan* by CIHI was downloaded on June 22nd, 2021, at which point the scan included policies announced between May 5th, 2020, and March 22nd, 2021 (CIHI, 2021). Next, document orientation was conducted in which all sheets of the excel file were read, including COVID-19 Intervention Scan, Notes to Readers, Table 1 Intervention Scan, Data dictionary, and Table 4 Version History. After identifying the data of interest was documented on sheet three, entitled *Table 1 Intervention Scan*, the following review of the table was initiated wherein particular attention was given to the *Intervention Summary*.

First, the data was sorted by "Jurisdiction," filtered to only include Ontario (Ont.) based policies and all policies implemented within Ontario jurisdiction were highlighted in blue to make them easily identifiable within the document. All filters were then removed, and the document was searched for terms "Ontario" and "Ont." in its entirety to ensure all Ontario policies were highlighted. The exact process was repeated for the jurisdiction of Canada wherein all federal-level policies or policies that were identified as "Canada" or "Can." were highlighted in orange. Within the newly highlighted document all relevant policies within Ontario and Federal jurisdiction, now easily identifiable by the previous steps, were sought out using a key term search. First, mental health policies within the relevant jurisdiction were identified using key terms or phrases "mental health," "psychosocial," and "psychological" were subsequently

highlighted in yellow. Additionally key terms or phrases related to PSWs, and their place of work were identified through key term search and highlighted in yellow including "Personal Support Worker," "PSW," "Health Care Aide," "Care Aide," "Home Support Worker," "Personal Attendant," "Community Development Service Member," "Patient Service Aide," "Frontline," "Frontline Healthcare Worker," and "Long-term Care". Next, the links provided in the *Primary Source* column of the highlighted interventions were followed and screened for the inclusion and exclusion criteria. Finally, the interventions that met the inclusion criteria were downloaded and subsequently analyzed using the aforementioned critical comparative policy analysis framework. Key information pertaining to the selected policies were subsequently documented, including term, frequency of the term, location index, and key context information (*see Table 2*). The topic specific selection was then reviewed using the probes and the WPR as well as themes were documented, including an illustrative quote and location index, to enable subsequent critical analysis of the policy (*see Table 3)*. Following the distinct selection, extraction, and analysis of the SARS and COVID-19 document respectively, a comparative review of the findings was conducted to conclude.

Findings

SARS Quantitative Findings

The *Learning from SARS – Renewal of Public Health in Canada* report by the NACSPH is a 234-page document that included a description of the Committee, Preface, Table of Contents, Executive Summary, Acknowledgements, twelve chapters, and one appendix. Through document orientation it was identified that the NACSPH was comprised of eleven committee members (p. ii). Of the eleven members, two were employed by Canadian universities (University of Toronto and Laval University). Five were employed by varying levels of

government including municipal (City of Toronto and Saskatoon), provincial (British Colombia), and federal (Canadian Public Health Association and Health Canada National Microbiology Laboratory). The final four committee members held employment associated with hospitals including the University Health Network, York Central Hospital, Mount Sinai Hospital, and St. Boniface Hospital. Additionally, the acknowledgements highlighted the contributions from employees of Health Canada, The Hay Group consulting firm, additional University of Toronto professors, US Centre for Disease Control, and the WHO.

A preliminary key term search for topic relevant terms was conducted wherein the relevant term, frequency, page number, and context were documented (*see Table 1*). No search terms regarding PSWs were present throughout the document, including Personal Support Worker, PSW, Health Care Aide, Care Aide, Home Support Worker, Personal Attendant, and Community Development Service Member. However, upon full document review, the job title *Patient Service Aide* was identified and included in the findings due to its probable reference to labour traditionally conducted by PSWs (*see Table 1*). Patient Service Aide was included once within the SARS document in reference to a description of respondents, a sub-category of FHWs, who took part in the roundtable discussion hosted by the Office of Nursing Policy on behalf of the National Advisory Committee on SARS and Public Health. While the key term "Frontline Healthcare Worker" produced no results, the key term Frontline returned five results (see Table 2, index p. 14, 67, 98, 117, 145), each used as a descriptor of labour and service provided during SARS. Finally, the key term Long-term Care produced 15 results (see Table 2, index p. 9, 26, 28, 31, 41, 121, 134, 142, 143, 145, 150, 172, 181, 202, 222), wherein the term was used in the discussion of cross-sector communication and acknowledgement of the Ontario Ministry of Health and Long-Term Care (OMHLTC).

In comparison to PSW related terms, key terms pertaining to mental health were more represented throughout the document, including Mental Health (19 results), Psychosocial (9 results), and Psychological (4 results) (see Table 2). Notably, the mental health terms were discussed in relation to five topics. Firstly, the document used the term "mental health" while outlining Canada's need to increase the coverage and funding of mental health services (see Table 2, index p. 5, 78, 83). Specifically, a $30 million per annum investment into mental health services, as well as environmental health and injury prevention, was briefly recommended (see Table 2, index p. 83). Further, the term "mental health" was used to establish support for a new agency that would increase the opportunity to engage in mental health needs of Canadians (see Table 2, index p. 78). Secondly, the key term "mental health" is used to describe the United States Health and Human Services as a comparison to Canada's healthcare spending and provision (see Table 2, index p. 59, 69). Thirdly, "mental health" was used in discussion of hospital admittance and stay of mental health patience, including admittance routes and bed occupancy trends (see Table 2, index p. 156, 158). Fourthly, the term mental health was in the summary of jurisdictional issues, specifically, provincial jurisdiction over involuntary committal for mental health reasons (see Table 2, index p. 166). Finally, the term was used in the outlining of the Personal Information Privacy and Electronic Documents Act (see Table 2, index p. 172).

Notably, the context in which the term *mental health* was used within the document is distinct from the context of the terms *psychosocial* and *psychological* (see Table 2). The term psychosocial was used exclusively to describe the mental health impact of SARS (see Table 2, index p. 11, 155, 187, 188, 211) and the capacity to respond to the needs of the public and FHWs (see Table 2, index p. 108, 216). Similarly, the term psychological was used in reference to the FHWs experience of stress (see Table 2, index p. 1, 20) and the need for proactive support (see

Table 2, index p. 181). Notably, discussions pertaining to the psychological or psychosocial experience during SARS excluded the use of the term *mental health*. Additionally, the discussion of the "Psychosocial Implications of SARS" (see Table 2, index p. 155) was comprised of 214 words total. While the above quantitative findings are predominantly descriptive in nature, they provide arguably vital context in which the following quantitative findings should be analyzed in.

SARS High-Level Qualitative Findings

A high-level qualitative analysis, as previously detailed, was conducted on the *Learning from SARS – Renewal of Public Health in Canada* report by the NACSPH. Due to the nature of the data, a high-level qualitative analysis was restricted to the SARS data only. Four prominent themes were identified throughout the report: including (1) Affirming Divisions of Power, (2) Limitations of Canadian Public Health Systems within PHE, (3) International Considerations, and (4) Establishing an Emergency Public Health Authority (see Table 1). Each theme illustrated a distinct goal of the document itself and, in turn, a more holistic understanding of the qualitative findings of the selected policies analyzed in the later sections of the present MRP.

Affirming Divisions of Power is a key ambition of the document. Functionally, the theme problematizes the lack of distinct authority and the unestablished divisions of power during PHEs. In doing so, the theme utilizes the language of responsibility by asserting that the provision of public health services remains unattainable within the existing vague structure. The following illustrative quote exemplifies the vague division of authority between F/P/T that is seemingly a key target of the document.

> "From a constitutional perspective, public health is primarily a provincial concern. However, the federal government has authority to legislate aspects of public health owing to its powers over, variously, the criminal law, matters of national concern for the maintenance of "peace, order and good government," quarantine provisions and national borders, and trade and commerce of an interprovincial or international nature. Behind the formal division of powers is an essential tension in the Canadian F/P/T fabric: much administrative responsibility rests with the provincial/territorial level, while revenue generation and therefore spending capacity is concentrated at the federal level." (see Table 1, index p. 2).

Throughout the document, the consumer is guided to the conclusion that the provision of public health services in a PHE is contingent on establishing a structure of power that is affirmed through capital means. It balances the narrative that the inadequate response to SARS as a consequence of non-distinguished authority, accentuating the utility and necessity of top-down management. This narrative is foundational to the document as it provides a clear culprit for critique that is associated with the government; however, it diverts the accountability away from the governments' practice toward an issue of jurisdiction. This theme serves as a means to separate the issue of under-resourcing and deprioritization of Canadian public health services in a PHE from government accountability. Through naming the inefficiency, it guides the reader to focus future PHE considerations on the structure of authority over the needs for healthcare provision. This problematization necessitates a clear solution of establishing a top-down structure of authority in response to PHE's thereby entrenching and affirming this distribution of power within policy.

The secondary high-level theme, *Limitations of Canadian Public Health Systems Within PHE*, is an essential component of the document as it is the declared orientation of the *Learning from SARS – Renewal of Public Health in Canada* report by the NACSPH. However, it is the natural extension of the above theme. While the theme is comprised of examples of the inefficacies of the Canadian public health system, including F/P/T public health funding, communications, capacity, and preparation, it does so in favour of designating a structure of F/P/T response to PHE. The following illustrative quote showcases the use of solving the identified limitations of the Canadian public health system predominantly as evidence for the broader narrative of asserting structures of authority within PHEs.

> "The Committee sees an urgent requirement for multijurisdictional planning to create integrated protocols for outbreak management, followed by training exercises to test the protocols and assure a high degree of preparedness to manage outbreaks. To create surge capacity, the F/P/T Network for Emergency Preparedness and Response has already been working towards establishment of Health Emergency Response Teams [HERT]. The HERT model has been developed as a multidisciplinary group of clinical and support personnel for "all hazards". The SARS experience highlights the need to mobilize selected groups of skilled personnel into epidemic response teams within the HERT framework." (see Table 1, index p. 6).

Although the value of identifying the ways the public health system is limited in its ability to attend to the demands of PHEs is clear, the process of problematization dismisses the system of production and frames the solution within high-level authority. Further, it ensures that the frontline experiences remain viewed as one of suffering and not wisdom. Each limitation

reviewed throughout the document calls back to the *necessary* top-down structure of public health by articulating that the success of healthcare provision is contingent on high-level management, not the expertise of FHWs.

A third fundamental theme embedded throughout the document is *International Considerations*, wherein PHEs are acknowledged as a globalized threat yet championed as an opportunity to further establish Canada in international spaces. The following illustrative quote exemplifies how Canada's restricted international presence, specifically in China, is problematized as a threat to Canadians and the "developing" countries traditionally located in the global south.

> "The Government of Canada should build health R&D (research and development) activities into its programs of international outreach. In particular, the new Canadian Agency for Public Health should have a mandate for greater engagement internationally in the emerging infectious disease field, and support projects to build capacity for surveillance and outbreak management in developing countries." (see Table 1, index p. 10).

This theme has a greater interest in asserting Canadian authority in an international space. By framing the well-being of Canadians in PHE contingent on Canada's international presence, the document provides justification for politicizing PHE's and increasing Canada's systems of international surveillance.

The fourth prominent theme present in the report is *Establishing an Emergency Public Health Authority*, that presents the holistic solution idealized throughout the aforementioned themes. The following illustrative quote showcases how the establishment of an emergency

public health authority was used to support and attend to the narrative curate throughout the reports.

> "The creation of an agency cannot depoliticize interactions among jurisdictions, but it can reduce the chances that the health of Canadians would inadvertently be held hostage in a jurisdictional disagreement among levels of government. Among our key recommendations therefore is that the Government of Canada create a new Canadian Agency for Public Health, led by a Chief Public Health Officer of Canada. A Canadian Agency for Public Health is arguably best structured as a Legislated Service Agency, analogous to the Canadian Food Inspection Agency, the Canadian Institutes of Health Research, or Statistics Canada. The Chief Public Health Officer of Canada would be the chief executive of the new federal agency and report directly to the federal Minister of Health." (see Table 1, index p. 4).

This theme is an amalgamation of the prior themes and the ultimate goal of the report. Throughout the documents detailing the proposed solution, it consistently calls back to the prior themes and the problematization embedded within them, seemingly to reiterate the broader narrative. Once more, the balance between acknowledging the under-resourced reality of Canadian public health with the reduction of government accountability is maintained to benefit a new structure of authority. Correspondingly, while a top-down management structure is championed to address the *issues* of jurisdiction, public health limitations, and international threats, the domestic production of exploitative conditions and concrete commitments to the frontline needs remain unacknowledged within the discourse.

SARS Selected Policies Qualitative Findings

The following qualitative findings were extracted from the relevant PSW, and mental health policies included in the *Learning from SARS – Renewal of Public Health in Canada* report by the NACSPH. Four pertinent themes, three pertaining to mental health and one pertaining to PSWs, were identified within the document: including (1) Mental Health: Renewing Systems of Public Health, (2) Mental Health: Regulating Access to Healthcare Services, (3) Mental Health: Psychological Considerations, and (4) PSW: Non-findings (see Table 3). Each theme illustrated the orientation toward the topics of focus for the present research.

Predictably, the themes within the selected policies reflect the high-level motivations of the document, with the first mental health theme, *Renewing Systems of Public Health*, as no exception. Mental health was included within the documents discourse to support the establishment of a public health authority. Mental health was explicitly identified as a largely underfunded sector, as depicted in the illustrative quote below.

> "The coverage of areas such as environmental health, mental health, and injury prevention is clearly suboptimal and taken together, could draw an extra $30 million per annum." (see Table 3, index p. 83).

Interestingly, the discussion of increased mental health funding inadvertently acknowledges and validates the value of mental healthcare. Furthermore, the discussion of mental health funding coincides with increased funding of environmental health and injury prevention, two public health sectors highly relevant to PSWs. Although further investment into mental health is vaguely proposed, unlike other recommendations such as the establishment of a public health authority, no concrete commitment or action plan is outlined to address the vague issue of mental health. Additionally, no explicit discussion of the antecedents to mental health outcomes was

included throughout the document. Due to the general discourse of mental health experience and the potential funding linked to the establishment of a public health authority, the inclusion of mental health seems an insincere attempt to attend to the frontline needs.

Another prominent theme within the mental health discourse was the *Regulating Access to Healthcare Services*. Mental health is most prominently discussed in terms of hospitalization due to mental health and route of access, not in relation to the broader public's mental health concerns or vulnerabilities as depicted below.

> "For medical and mental health patients, the most common route of entry to the hospital is via the ED (emergency department)" (see Table 3, index p. 156).

The theme reviews the ways the public engages care and hospital settings. However, it frames mental health as a concern only in the space of hospitalization and not extended in the public or labour space further separating the provider of care from the access of care. This establishes a need to attend to the heightened mental health risk of those in most dire circumstances, however, it relies on frontline workers, thereby neglecting their experience.

The final mental health theme evident within the document are the *Psychological Considerations*, wherein subtle yet critical distinction is made throughout the document between *mental health* and *psychological/psychosocial*. Although both convey a similar experience of adverse mental health outcomes when in relation to FHWs, the experience is only framed as *psychological implications* or *psychological stress* throughout the document. By contrast, the document acknowledges *mental health* as an experience and extension of health only as it pertains to hospital services or public health structures. The following quote exemplifies the pattern of acknowledgement of potential heightened mental health distress of FHW through duplicitous language.

> "Health care workers caring for SARS patients were at heightened risk for contracting a new and dangerous disease and worked under physical and psychological stress." (see Table 3, index p. 1).

This semantic choice was arguably intentional in order to reduce the perception of the severity of the FHW mental health experience. Additionally, it serves to distract from the link between the FHW mental health outcomes and the discussion of how under resourced the workplace setting, and mental health services are within Canada. Regardless of the motivation, this distinction is detrimental as it disconnects adverse mental health outcomes experienced by the public and those of FHWs, thereby reducing the FHWs mental health distress as an occupational hazard. This framing supports the acceptance of exploitative circumstances that produce the socially sanctioned sacrificing of FHWs' mental health within PHE.

Acting as the final pertinent theme identified within the emergency policy response to SARS is the exclusion of PSWs in their entirety throughout the *Learning from SARS – Renewal of Public Health in Canada* (NACSPH) report. The complete lack of dialogue pertaining to PSW's was evident throughout the document showcasing PSWs position and value within the labour hierarchy of public healthcare. This upholds and subtly affirms the general and PHE specific exploitation and disregard of this predominantly feminized and racialized workforce. Their exclusion may have larger implications as it leaves PSWs vulnerable to be forgotten, neglected, or deprioritized in future policy action and renewed systems of public health.

COVID-19 Quantitative Findings

At the date of download, June 22nd, 2021, the *COVID-19 Intervention Scan* by CIHI had undergone seven updates since initial publication on June 20th, 2020, to include policy action announced from January 25th, 2020, up until March 22nd, 2021. The downloaded document detailed 3,688 policy entries. The scan documented policy action across Canada and all F/P/T jurisdictions.

Firstly, key terms pertaining to Personal Support Workers, including Personal Support Worker, PSW, Health Care Aide, Care Aide, Home Support Worker, Personal Attendant, Community Development Service Member, and Patient Service Aide (see Table 2). The key term Personal Support Worker resulted in four policies; the federal government announced a $23.2 million investment to accelerate the development and training of PSWs (CAN241). Additionally, the province of Ontario announced a $100 million investment to increase nursing and PSW hours (see Table 2, index ON262), a $610 million funding for PPE and supplies for FHW including PSWs (see Table 2, index ON273), and a hospital to home transition program entitled High Intensity Supports at Home intended to increase PSW hours (see Table 2, index ON375). Additionally, the key term PSW identified the announcement of the temporary hourly wage increase for PSWs (see Table 2, index ON453).

Upon further review of the intervention scan, the key term Frontline and Frontline Healthcare Worker was included to ensure the inclusion of PSW relevant policies that generalized to all FHWs (*see Table 2*). The term Frontline returned ten results and six relevant to the population of interest within the jurisdictions of interest. At the federal level, the key term identified the Amazon Canada agreement for PPE and critical supply distribution (see Table 2, index CAN053) and provision of retroactive compensation of Expectational Hazard Allowance

of $78/day for the deployed Canadian Armed Forces (see Table 2, index CAN137). At the provincial level, the key term highlighted policies pertaining to the eligibility expansion of free emergency childcare (see Table 2, index ON091, ON142), a temporary $4/hour wage increase for eligible healthcare staff (see Table 2, index ON139), and the COVID-19 vaccine roll-out prioritization of FHWs (see Table 2, index ON406). The following key terms yielded no results, Health Care Aide, Care Aide, Home Support Worker, Personal Attendant, Community Development Service Member, and Patient Service Aide, and Frontline Healthcare Worker.

Additionally, key term pertaining to long-term care homes, a primarily PSW healthcare setting, was included in the policy searched using Long-Term Care resulting in 35 population and jurisdictionally relevant policies (see Table 2). At the federal level policies that used the key term Long-Term Care included interim infection control and prevention guidance (see Table 2, index CAN011), online COVID-19 assessment tool for FHW (see Table 2, index CAN037), the deployment of the Canadian Armed Forces to Ontario long term care homes (see Table 2, index CAN103), and a $186.8 million investment in long term care home support (see Table 2, index CAN244). Within the province of Ontario the key term returned relevant policies pertaining to resident/visitor guidelines (see Table 2, index ON024, ON188, ON247, ON248, ON282, ON289, ON294, ON335), COVID-19 testing (see Table 2, index ON001, ON078, ON120, ON152, ON258, ON358, ON454), vaccination (see Table 2, index ON385, ON406, ON437, ON479), PPE provisions (see Table 2, index ON085, ON151, ON271), staffing or personnel support (see Table 2, index ON035, ON088, ON136, , ON151, ON161, ON304, ON375, ON438), staff compensation/pandemic pay (see Table 2, index ON139), emergency orders (see Table 2, index ON164), and the launch of independent COVID-19 commission (see Table 2, index ON225).

Finally, the key terms pertaining to mental health were searched, including "Mental Health" (3 results), "Psychosocial", and "Psychological" (1 results) (see Table 2). Only two of the three policies that used the term "Mental Health" had implications for the province of Ontario. The first policy was announced in May outlining the federal $240.5 million investment in virtual care and mental health tools (see Table 2, index CAN098), followed by the deployment of mental health professionals and supplies to first nation communities in Ontario, Manitoba, and Alberta within the same month (see Table 2, index CAN113). While the key term "psychosocial" produced no results, the key term psychological returned one policy that detailed the Canadian Psychological Associations (CPA) guidelines virtual mental health care practice (see Table 2, index CAN081).

COVID-19 Selected Policies Qualitative Findings

The following qualitative findings were extracted from the relevant PSW, and mental health policies included in the *COVID-19 Intervention Scan* by CIHI. Six pertinent themes, two pertaining to mental health and four pertaining to PSWs, were identified within the document: including (1) Mental Health: Renewing Systems of Public Health, (2) Mental Health: Regulating Access to Healthcare Services, (3) PSW: Practice Guidelines Considerations, (4) PSW: Acquiring Critical Supplies, (5) Human Resources, and (6) Long-term Care Setting (see Table 3). Each theme illustrated the policy response's orientation toward the topics of focus of the present research.

The first emerging mental health theme evident within the emergency policy response to COVID-19 is *Renewing Systems of Public Health*. Within the limited mental health policies enacted during COVID-19, the most notable seek to optimize the window of opportunity

produced by the PHE by expediting financially controversial processes of revitalization. Similar to the themes' SARS construction, it recognizes mental health as a valued and important aspect of health. As depicted in the illustrative quote below, the concept of mental health has seemingly evolved into a health risk of the Canadian public.

> "The Prime Minister, Justin Trudeau, today announced an investment of $240.5 million to develop, expand, and launch virtual care and mental health tools to support Canadians." (see Table 3, index CAN098).

The above policy indicates that, like during SARS, mental health remains a largely underfunded sector of public health. However, despite seemingly acknowledging this reality, the commitment remains vague as the investment in mental health is yet again grouped with additional sectors. Furthermore, the policy action furthers the separation of healthcare providers and those who access care. While the illustrative quote exemplifies how health is being framed as a more fluid, less traditional institution of healthcare, such as a hospital, the policy assumes that all Canadians are equally able to engage in mental health *tools* regardless of restricted resources such as time. In doing so, FHWs are isolated from the public as the providers of care and not those who engage with healthcare. Furthermore, it frames mental health as an individual issue; therefore, requiring a solution that is equally reliant on the individual. However, this neglects the exploitative conditions in federal control that may produce the mental health decline.

The second mental health theme emerging in the COVID-19 policy response is *Regulating Access to Healthcare Services*. Like SARS, this theme was used as a tool to further the construction of a narrative within COVID-19. The theme frames the idea that remote and largely First Nations and Indigenous groups require emergency healthcare intervention. The following

illustrative quote details the decision to deploy human resources to remote communities in Ontario by framing it as a function of accessing care, yet it is predominantly a military operation.

> "Future flights are planned for May 20, June 3 and June 17 to fly-in communities in Ontario, Manitoba and Alberta for nurses, as well as other health care providers such as doctors and mental health service providers. Flights will then continue every four weeks until it is safe to return to the previous process. Other flights may be scheduled to bring cargo or other critical personnel such as professionals needed to maintain or fix critical infrastructure if additional needs are identified." (see Table 3, index CAN113).

While providing support to remote communities is required in various forms such as providing critical supplies, regulation of food prices, and ensuring clean drinking water, it does not necessitate the policing of these communities. The COVID-19 policies reflective of this theme function to assert the government's authority within a PHE. Furthermore, as made exemplified in the illustrative quote, no references are made to indicate that the deployed *critical personnel* are either culturally informed or adequately resourced to attend to the needs of the communities. Thereby, the theme frames the provision of healthcare in a PHE as an issue of access and not quality of care.

The first prominent PSW theme emerging within the COVID-19 policy response is *Practice Guidelines*. Mirroring the FHWs experience of SARS, PSWs have been subject to a stream of inconsistent directives that impact their frontline practice and industry stability. This theme is reflective of the top-down "adaptive", yet disorganized approach seemingly employed by Canadian policymakers to address PHEs. The selected quotes illustrate this approach while

exemplifying both the disconnect between the policymakers and FHWs as well as their naïve understanding of the PSW working conditions.

> "The government has also issued an emergency order directing long-term care employers to ensure their employees, including registered nurses, registered practical nurses, personal support workers, kitchen and cleaning staff only work in one long-term care home. This means that employees cannot work in multiple locations such as a retirement home or other health care setting." (see Table 3, index ON088).

This selected directive restricts PSWs, who predominantly work multiple part-time jobs due to a lack of full-time employment opportunities, to one worksite or institution, thereby reducing their income. Further, these directives inadvertently understaffed the long-term care facilities while increasing the labour demand on those employed. While one of many attempts to reduce the spread of COVID-19, this theme is not viable as it mandates a practice that reduces the resources further within an already exploitative setting. During the SARS epidemic, a need to increase human resources (i.e., qualified professionals) was problematized, yet the framing actively neglected to consider the lack of resources was a lack of individuals willing or forced to work in the exploitative position. This is reflected in the COVID-19 pandemic, where PSWs are burdened with adjusting to the naïve directives while upholding a standard of care that is not reflected in the resources provided to them.

The second emerging COVID-19 theme pertaining to PSWs was *Acquiring Critical Supplies*, including PPE. The following illustrative quote showcases one of a series of mandates enacted to increase the purchase, creation, acquisition, and distribution of critical public health supplies in defence of COVID-19.

> "Funding of $610 million for the purchase of personal protective equipment and other critical supplies." (see Table 3, index ON237).

Notably, this emerging theme inadvertently highlights the lack of consideration for the SARS *lesson* that indicated the need for a national supply of critical supplies in order to prepare for future public health emergencies, such as the present COVID-19 pandemic. Following SARS, the province of Ontario initially created an emergency stockpile of PPE, including masks; however, with political turnover maintaining a functional stockpile was financially de-prioritized, leading to the provincial emergency supply of critical supplies to be expired and non-functional. The theme emphasizes the true extent of under resourcing the frontline public health system remains. Additionally, PSWs position within the healthcare labour hierarchy was illustrated in the distribution of the acquired critical supplies. PSW's remained at greater risk as the public healthcare settings were prioritized for the provision of critical supplies. Additionally, the privatized long-term care homes were initially tasked with acquiring their own supply of PPE.

The third PSW theme reflected in the COVID-19 policy response is *Human Resources*. While the theme is intertwined in the broader discussion of funding and capacity that was evident during SARS, it functions to both value PSW labour while maintaining their utility as a primary tool in the COVID-19 defence. The following illustrative policy illustrates the OMHLTC's appraisal of PSWs' contribution to emergency public health response.

> "In recognition of the dedication, long hours, and increased risk of working to contain the COVID-19 outbreak, the Ontario government is providing frontline staff with a temporary pandemic payment. This increase will provide four dollars per hour worked on top of existing hourly wages, regardless of the qualified

> employee's hourly wage. In addition, employees working over 100 hours per month would receive lump sum payments of $250 per month for each of the next four months. This means that eligible employees working an average of 40 hours per week would receive $3,560 in additional compensation. Those eligible to receive the payment will be staff working in long-term care homes, retirement homes, emergency shelters, supportive housing, social services congregate care settings, corrections institutions and youth justice facilities, as well as those providing home and community care and some staff in hospitals." (see Table 3, index ON139).

This directive exemplifies one of a series of temporary *pandemic pay* mandates to benefit frontline healthcare workers. Unfortunately, due to PSWs predominantly being employed in part-time positions in a single facility, PSWs are largely ineligible for the full extent of compensation provided to workers who work over a certain number of hours. Notably, the general $4.00 per hour increase for one part-time employee, working the upper limit of 30 hours per week (Statistics Canada, 2016), equates to an increase of $24.00 per day or $120.00 per week. This seems inconsequential when compared to the compensation provided under Operation LASER (CAN103), wherein military operatives deployed to the same long-term care facilities in response to COVID-19 received standard pay and an addition of $78/day under hazard pay. Provided the military personnel was compensated for part-time hours, their *pandemic pay* equates to an additional $390.00 per week. This comparison illustrates the harsh valuation made of PSWs. Moreover, the theme frames the lack of PSWs as an issue reminiscent of SARS problematization wherein the lack of *human resources* focused on a lack of *qualified*

professionals (as depicted in additional policies i.e., CAN241), and not reflective of exploitative working conditions or lack of regulation.

The final pertinent PSW-related theme emerging within the emergency policy response to the COVID-19 was *Long-term Care Setting*. The majority of COVID-19 policies that impact PSWs were indirectly mandated through the primary space of employment i.e., privatized long-term care homes. The following illustrative excerpt showcases this pattern while inadvertently acknowledging the urgency of the under resourcing permitted within this sector of healthcare in Ontario.

> "The Ontario government is investing close to $540 million to protect residents, caregivers, and staff in long-term care homes from future surges and waves of COVID-19. The funding is part of the province's COVID-19 fall preparedness plan, Keeping Ontarians Safe: Preparing for Future Waves of COVID-19." (see Table 3, index ON271).

The depicted investment was a response to the increase of deaths from COVID-19 and conditions of long-term care facilities witnessed by the media and public. Upon initial consideration, one may assume the inclusion of PSWs is an unintentional yet welcomed consequence of their dominant employment within the space. However, it may also be reflective of the non-existent regulatory body of PSWs as applying a directive to a non-regulated labour force is seemingly semantically and functionally impractical. It is evident that PSWs are effectively regulated through the regulation of the long-term care setting. Despite efforts to oppose the formal regulation and recognition of PSWs throughout Ontario's history, a PSW regulatory act was strategically announced entitled *Health and Supportive Care Providers Oversight Authority Act*. With such an assertive name it is unsurprising that the proposed act

provides the government increased authority while not attending to the working conditions of the PSW across the private and public healthcare sector. This seemingly reflects an interest in regulating the access to work, the production of labour, and the reproduction of exploitative conditions.

Discussion

Key Findings Reflection

As the COVID-19 pandemic encroaches upon yet another year as an international threat to public health, the mental health outcomes of the primary frontline defense, PSWs and additional FHWs, has only become a more imminent concern. While a complete generalization of the present findings may not be appropriate, the undeniable continued inadequacies in Canada's emergency policy response to attend to the mental health of essential FHWs (e.g., PSWs) showcases a consistent vulnerability in Canada's emergency response protocols. As anticipated, the present study indicates that the mental health distress that PSWs have been subjected to during COVID-19 could have been mediated, if not avoided altogether, if the emergency response had prioritized PSWs beyond their utility as labourers.

The policy response to SARS and COVID-19 followed comparatively similar patterns as evidenced in the following themes: acquiring critical supplies, human resources, long-term care setting, renewing systems of public health, regulating access to healthcare services, and psychological considerations. Overall, although the mental health considerations during SARS were far fewer than the COVID-19 policy actions, both SARS and the COVID-19 response provided negligible supports that neglected to account for broader mental health contributors. Similarly, PSWs seemingly received substantial increase in consideration in the present COVID-19 pandemic in comparison to SARS just on the mention of the workforce in a policy altogether.

However, the inclusion of PSWs was focused on their utility as labourers amid the pandemic and less about ensuring their well-being and longevity on the frontlines of the emergency. Furthermore, while the explicit mental health and FHW policy considerations remain few and far between, policies that accounted specifically for the mental health of FHW remained elusive in both SARS and COVID-19. While the discourse seemingly acknowledged their vulnerability to adverse mental health outcomes, policies with a surface potential to provide mental health support to PSWs lacked in function.

While the replication of SARS's inconsiderate policies throughout COVID-19 for PSWs, a feminized, racialized, low-wage workforce, may be described as an oversight, there is utility for some in the inequitable policy response. The policy action taken to address mental health, PSWs, or the mental health of PSWs was evidently insufficient for the articulated concerns. However, they did serve to inform a far more prioritized goal in the face of emergency - reaffirming inequitable distributions of power through policy response. Within policy response to SARS, one imposing policy action is the erection of an entire regulatory sector of public health (i.e., PHAC) providing further avenues to execute authority. Blatantly showcasing which lessons were truly taken from SARS, Ontario policy makers took the opportunity to expand and affirm their legislative authority by forming a PSW regulatory body as a solution to the COVID-19 PSW experience. Further, the militarization of long-term care spaces through operation LASER in lieu of a means to exert authority over PSWs accompanied by the shocking discrepancies in compensation between the military and FHWs further exemplifies the active reproduction of the "lessons" learned from SARS during COVID-19.

Political, Social & Development Contextual Considerations

To understand the policies chosen for implementation it is important to understand broader driving forces that may have influenced Canada's approach. The Canadian SARS epidemic gained international recognition due to the mismanagement of the PHE. While Canada accredited the inability to attend to SARS was largely based their reliance on the WHO to verify public health information, the estimated economic loss of $3.2 billion resulting from the SARS (Keogh-Brown & Smith, 2008) showcases a domestic inefficacy. Interestingly, in the face of the economic strain of SARS, China became Canada's second largest trading partner in 2003 (Martin, 2005). The evolving international relations and urgency for independent authorities in international spaces may have further inspired the push to establish an internationally acknowledged agency, such as PHAC, which was subsequently formed. In addition to the international attention and relations, Canada underwent notable political transitions at both federal and provincial levels increasing a political need to reinforce domestic distributions of power. Of particular interest was the change in federal leadership within the liberal party during a non-election year. The Canadian prime minister Jean Chretien, elected in 1993, resigned his position amid scandal to Paul Martin, liberal minister of Finance, who would go on to hold the position until 2006 (Bothwell et al., 2012; Hillmer & Azzi, 2007). Similarly, Ontario underwent an election wherein the province experienced a change in leadership and political party from Progressive Conservative leader Ernie Eves, elected in 2002, to Liberal leader Dalton McGinty (Demont, 2003). Seemingly in response to SARS and the political shifts, Canada established the Council of Federation, an annual conference, that enabled political leaders throughout F/P/T jurisdictions to unify in funding negotiations and increase cross jurisdiction communication (Collins, 2018).

Contrasting the SARS epidemic, the provincial leadership remains constant with progressive conservative Premier Doug Ford, elected in 2018, as the leader for Ontario at the provincial level (Kucharsky, 2020). While this leadership has remained constant throughout the COVID-19 pandemic to date, Ontario is slated for an impending provincial election scheduled in 2022. At the federal level, Liberal Prime Minister Justin Trudeau, first elected in 2015 and re-elected for a second term in 2019, called for a "snap election" for 2021 in the midst of COVID-19 two years ahead of the federal election schedule (Wherry, 2021). A seemingly redundant act as Liberal Prime Minister Justin Trudeau remains the Canadian prime minister at the federal level (Wherry, 2021). In addition to government structure, the "hero" centric rhetoric employed by both leadership and the media are noteworthy. While reports on the maltreatment of FHWs became increasingly mainstream, such as the military report on long-term care homes (Carter, 2020), so did the proverbial knighting of FHWs as heroes in the media (e.g., Simmons, 2020; Bresge, 2021).

Of arguably greater relevance to the population that comprises the PSW labour force the anti-racism movement known as Black Lives Matter (BLM) gained unprecedented attention within Canada. BLM began as a political protest of the police murder of Trayvon Martin in 2013 and grew into the social movement against anti-black racism and police brutality (Oyeniran, 2020). During the COVID-19 pandemic the Toronto chapter, BLM-TO, rallied protests in demand of defunding the police throughout Ontario (Oyeniran, 2020). As a result, it was mandated that Ontario police officers report the race of individuals who have a weapon drawn on them or sustain injury due to police interaction (Oyeniran, 2020). The systemic injustice of racism within Canada was only made more evident in May 2021 when the remains of 215 indigenous children were identified in unmarked graves at Kamloops Indian Residential School

site (Marshall & Gallant, 2021). Moreover, similar to trends recorded throughout SARS there has been a rise in anti-Asian hate crimes leading to an official response by the federal government of Canada (Ng & Chagger, 2021). It is important to note that the increased mainstream discourse surrounding racial inequities may be imposing pressure on the policy makers to enact policies regarding groups, such as PSWs, in a way that attends to public demands of equity while serving less articulated goals (i.e., the observed insufficient regulation of PSWs and misleading pandemic pay).

Implications

Policy Implications

Immediate policy action should be taken to compensate for the insufficient consideration of the mental health of FHWs, specifically PSWs. As stipulated in the lessons learned from SARS, increased funding should be provided to healthcare for the areas of mental health, workplace/environmental health, and workplace injury (p.83). In addition, two decades have passed since the SARS epidemic in 2003, and thus the policies surrounding mental health should reflect its evolved validity in healthcare. Comprehensive proactive and protective mental health measures for FHWs informed by both research and the community itself should be instated. Such measures could include the essential maintenance of PPE supply as a lack of PPE has been extensively cited as a source of adverse mental health outcomes (Chirico et al., 2020; Cui et al., 2021; De Kock et al., 2021; Gómez-Salgado et al., 2020; Nelson et al., 2020; Pearce, 2020; Rizos et al., 2020; Tracy et al., 2020; Vera San Juan et al., 2020). Additional sources of mental health distress that could be address through policy action include inaccessible social support or social isolation (Chirico et al., 2020; Cui et al., 2021; Gómez-Salgado et al., 2020; Greenberg et al., 2020; Nelson et al., 2020; Sanghera et al., 2020; Stuijfzand et al., 2020; Tracy et al., 2020;

Vera San Juan et al., 2020; Wise, 2020), and high workload and understaffing (Chirico et al., 2020; De Kock et al., 2021; Gómez-Salgado et al., 2020; Greenberg et al., 2020; Pearce, 2020; Sanghera et al., 2020; Vera San Juan et al., 2020). Most interestingly, policy makers would not be required to conceive innovative policies as proposed solutions to the issue have been document in the literature already including the provision of accessible professional mental health support (Chirico et al., 2020; Gómez-Salgado et al., 2020; Greenberg et al., 2020; Nelson et al., 2020; Pearce, 2020; Sanghera et al., 2020; Stuijfzand et al., 2020; Tracey et al., 2020; Vera San Juan et al., 2020), consistent trauma and team debriefs (Gómez-Salgado et al., 2020; Greenberg et al., 2020; Nelson et al., 2020; Pearce, 2020, Rizos et al., 2020; Tracey et al., 2020), clear directives and communication on emergency policy measures (Gómez-Salgado et al., 2020; Greenberg et al., 2020; Nelson et al., 2020; Pearce, 2020; Vera San Juan et al., 2020) and long-term active mental health checks (Chirico et al., 2020; Greenberg et al., 2020; Nelson et al., 2020; Pearce, 2020; Sanghera et al., 2020; Stuijfzand et al., 2020).

While the implementation of proactive and protective policies regarding the mental health of PSWs could only be viewed as a success, the measures themselves will be threatened by Canada's welfare structure. As seen in the policy response to SARS the active problematization of authority ensured the establishment of an entire governing body for public health, PHAC, while allowing additional crucial policy measures such as PPE reserves, mental health supports, and healthcare staffing concerns to be deprioritized. This is evident during COVID-19 with the establishment of a PSW regulatory body not designed for PSWs but of PSWs. This is to say that Bill 283, *Health and Supportive Care Providers Oversight Authority Act*, is more concerned with regulation of PSWs and not for PSWs benefit. Bill 283 seemingly establishes both in name and practice a means to exert authority and mediate the production of

labour across the private and public healthcare sector. Moreover, it seeks to establish authority without substantive unionization or a means to uphold the workers' rights and well-being of PSWs. Bill 283 showcases the prioritization of affirming inequitable distributions of power through policy. While it should be amended to include the protections of PSWs health and rights at a minimum it exhibits how the underpinnings of the emergency policy response remains driven by capitalist motives that seek to reproduce inequity. The reality is that the PSW workforce is increasingly becoming increasingly racialized and feminized thereby subjecting the workforce to the structural inequities historically imposed upon those groups. Unsurprisingly, within a capitalist system that is designed to ensure empowering policies fail over time, basic policy action that should be implemented, such as mental health support, funding, and regulation, will never be enough to compensate for the production of inequities upon which they would be established.

Research Implications

The present research remains a snapshot of the emergency policy responses' consideration of the mental health of FHWs as the scope was unable to accommodate the continuously evolving COVID-19 pandemic and respective policy response. Future research efforts may develop the present findings by conducting a full PHE policy review following the conclusion of the COVID-19 pandemic. Furthermore, additional research may expand on the jurisdiction, FHW designations (e.g., nurses), and PHE policy comparators (e.g., H1N1). Such research would provide further insight into utilization of emergency policies beyond the hegemonic discourse and ultimately support FHW advocacy for proactive mental health protections against inevitable PHEs. Moreover, further investigation into the intersection of

frontline healthcare workers, mental health, gender, and race within the context of COVID-19 is required in order to understand the true scope of the mental health inequity during emergencies.

Limitations

Design

The present MRP, like any research endeavour, is subject to limitations by design that require reflection. Presently, the COVID-19 pandemic remains an evolving PHE therefore requiring continued policy action and emergency public health provision. Correspondingly, the COVID-19 data selected for the present MRP, the *COVID-19 Intervention Scan* by CIHI, is undergoing continuous development and therefore a conclusive comparative critical policy analysis is limited while the pandemic is on-going. Despite this drawback and the lack of a comparable summary report to that of the selected data for the 2003 SARS epidemic, it is anticipated that the policies implemented within the first calendar year are reflective of the government's policy priorities and foundational emergency policy approach to COVID-19. Lastly, the COVID-19 data set available for public use is produced by CIHI. Although CIHI remains a reputable government controlled not-for-profit institution, the *COVID-19 Intervention Scan* data and accuracy is restricted to the scope and search strategy outlined by CIHI. Similarly, the SARS data, the *Learning from SARS – Renewal of Public Health in Canada* report by NACSPH, is comprehensive yet limited to the scope outlined within the document.

As previously detailed, policies explicitly pertaining to PSWs, and mental health were selected for analysis through a standard key term and relevant phrase search strategy. However, it is important to note that PSWs and their experience of mental health is not limited to the intersection of policies that explicitly include PSWs or mental health. Consequently, while the strategy ensures the research remains in its scope of outline there is potential for policies that

have direct impact on PSWs, and their mental health may have been excluded by design. Additionally, present research was restricted to Federal and Provincial policies with direct implications on the province of Ontario. While the jurisdiction limits remain beneficial to the present research goals, it does neglect the broader Canada context and the ways in which inter-F/P/T relations may influence and impact the policies implemented in response to COVID-19. Similarly, the present study did not review COVID-19 or SARS policies implemented by individual institutions, including hospitals or long-term care homes.

Researcher Positionality

Lastly, as the principal investigator my personal interests in this research may have influenced the present MRP. Although I do not have lived experience as an FHW, my research interest is inspired by the experience of my friends and family who are working on the frontlines of healthcare during the on-going COVID-19 pandemic. It was through my community that I came to recognize the unique and inequitable mental health experience that FHWs endure during PHEs as a result of their occupation and the emergency policy response. While my proximity to the topic and continuing mental health advocacy may have impacted the critical engagement with the policies and MRP findings, I believe it primarily served to strengthen the present research. Most noteworthy, as a white cis female, whose Marxist Feminist theoretical orientation encourages critical analysis of the production of inequity rather than illustrative description of the experience, both myself and my present research cannot adequately speak to the depth of mental health inequity endured by the predominantly racialized workforce of PSWs.

Conclusions

The COVID-19 pandemic demands an unprecedented global and international response that is able to adapt to the continuously evolving threat to public health. It is clear that the vital role FHWs play in Canada's response to PHEs places FHWs mental health in jeopardy. Canada's response to SARS and the present COVID-19 pandemic is no exception. Amongst the endless policy noise resides the reality of perpetuating inequities through masqueraded policy action. To neglect the physical and mental health of the frontline healthcare workers who are providing the healthcare to Canadians in the face of COVID-19 is to bite the hand that feeds us. In order to improve the health outcomes of Canadians and ensure the efficacy of the Canadian healthcare system, the health, both physical and mental, of frontline healthcare workers must be considered a priority within emergency provisions. George Santayana (1905) wrote that "those who cannot remember the past are condemned to repeat it," a sentiment that bears truth and contemplative meaning when considering the SARS and COVID-19 policy response. Such policy action in the face of public health emergencies exemplifies that forgetting the past poses as great a threat as what is chosen to be remembered and thereby reproduced.

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List of Abbreviations

BIPOC: Black, Indigenous, People of Colour

CCAC: Community Care Access Centre

CIHI: Canadian Institute for Health Information

COVID-19: SARS-CoV-2 or Novel Coronavirus

CPIP: Canadian Pandemic Influenza Preparedness: Planning Guidance for the Health Sector

FHW: Frontline Healthcare Worker

F/P/T: Federal, Provincial, and Territory

HPRAC: Health Professions Regulatory Advisory Council

IHR: International Health Regulations

MRP: Major Research Project

NACSPH: National Advisory Committee on SARS and Public Health

NAPAPI: North American Plan for Animal and Pandemic Influenza

OHPIP: Ontario Health Plan for a Pandemic Influenza

OMHLTC: Ontario Ministry of Health and Long-Term Care

PHAC: Public Health Agency of Canada

PHE: Public Health Emergency

PIRM: World Health Organizations Pandemic Influenza Risk Management

PPE: Personal Protective Equipment

PSW: Personal Support Worker

SARS: SARS-CoV or Severe Acute Respiratory Syndrome

SDPSSO: Self-Directed Personal Support Services Ontario

WHO: World Health Organization

WPR: What is the Problem Represented to be

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Table 1

Comparative Critical Policy Analysis: High-Level Qualitative Analysis of Selected Policies

Document	Theme	Illustrative Quote	Index	Critical Analysis
SARS: *Learning from SARS – Renewal of Public Health in Canada* by NACSPH	Affirming Divisions of Power	"From a constitutional perspective, public health is primarily a provincial concern. However, the federal government has authority to legislate aspects of public health owing to its powers over, variously, the criminal law, matters of national concern for the maintenance of "peace, order and good government," quarantine provisions and national borders, and trade and commerce of an interprovincial or international nature. Behind the formal division of powers is an essential tension in the Canadian F/P/T fabric: much administrative responsibility rests with the provincial/territorial level, while revenue generation and therefore spending capacity is concentrated at the federal level."	p. 2	o This theme problematizes the disintegration and disorganization of divisions of power observed during SARS throughout the local, provincial, federal, and international spaces. The theme frames the issues identified in the policy response to SARS as an issue of distinctions of authority and high-level management. o Distinct from the theme *Establishing an Emergency Public Health Authority* detailed below, this theme outlines the utility of high level of government. While seemingly critiquing the existing structure of government and public health, it is not a critique of practice but of jurisdiction. This is vital as it shapes the government's inability to adequately attend to PHEs as an issue of non-established authority across public health spaces and not an issue of their practice of provision. o This theme serves as a means to separate the issue of under-resourcing and the *Limitations of Canadian Public Health Systems within PHE* (detailed below) from government accountability by naming the inefficiency as a result of limited pan-Canada authority thereby seemingly redirecting the narrative throughout the document to affirm that the divisions of power during PHEs should reside with high-level government and not the FHW's. o The problematization leads the reader to focus future PHE considerations on structure of authority over the needs for healthcare provision. It provides the foundation for the primary focus of the document which necessitates a top-down structure of authority in response to PHE's thereby entrenching and affirming this distribution of power within policy. o Theme evident in sections such as "Public Health in Canada: Organization and Jurisdiction," "International Models," "A New Canadian Agency for Public Health," "Federal Funding to Renew Public Health across Canada," "Communicable Disease Control and Health Emergency Management," "Public Health Partnerships Program," "Regional and Clinical Issues," "Building Capacity and Coordination: National Infectious Disease Surveillance, Outbreak Management, and Emergency Response," and "Some Legal and Ethical Issues Raised by SARS and Infectious Diseases in Canada"

Table 1 continued

Comparative Critical Policy Analysis: High-Level Qualitative Analysis of Selected Policies

Document	Theme	Illustrative Quote	Index	Critical Analysis
SARS: *Learning from SARS – Renewal of Public Health in Canada* by NACSPH	Limitations of Canadian Public Health Systems within PHE	"The Committee sees an urgent requirement for multijurisdictional planning to create integrated protocols for outbreak management, followed by training exercises to test the protocols and assure a high degree of preparedness to manage outbreaks. To create surge capacity, the F/P/T Network for Emergency Preparedness and Response has already been working towards establishment of Health Emergency Response Teams [HERT]. The HERT model has been developed as a multidisciplinary group of clinical and support personnel for "all hazards". The SARS experience highlights the need to mobilize selected groups of skilled personnel into epidemic response teams within the HERT framework."	p. 6	o This theme reviews the inefficacies in the Canadian public health systems ability to attend to the demands of PHEs with particular focus on F/P/T public health funding (p. 5), communications (p. 7), capacity (p. 8), and preparation (p. 6). o This theme explores the many ways the public health system is under-resourced. It frames the issue as one of frontline function as a result of the disorganization throughout Canada's Public Health system providing tangible evidence of the problem of vague divisions of power. o While it is vital to identify the areas of public health that are under-resourced or limitations in an emergency, the theme functions as *evidence* for the aforementioned issue of divisions of power during PHEs. Although it identifies key inadequacies such as those depicted in the illustrative quote, the root of the issue is arguably misidentified as the lack of F/P/T government authority and not the governments' response to the needs outlined by FHW in the face of a PHE. o This theme is a natural extension of the aforementioned theme and aids the broader argument of a high-level system overhaul and management system while the need to equip existing systems or frontline healthcare workers with the resources they require remains unacknowledged. It upholds the value of a high-level authority while simultaneously arguing that FHWs are not able to sufficient in their ability to attend the public health needs of Canadians within the system thereby showcasing the lack of infrastructure while neglecting to assert the exploitative working conditions endured across the healthcare sector. o Within each limitation reviewed throughout the document it calls back to the *necessary* top-down structure of public health by articulating that the success of healthcare provision contingent on high-level management, not the expertise of FHWs. o Theme evident in sections such as "A New Canadian Agency for Public Health," "Building Capacity and Coordination: National Infectious Disease Surveillance, Outbreak Management, and Emergency Response," "Communicable Disease Control and Health Emergency Management," "Enhancing the Public Health Infrastructure: A Prescription for Renewal.," and "Federal Funding to Renew Public Health across Canada"

Table 1 continued

Comparative Critical Policy Analysis: High-Level Qualitative Analysis of Selected Policies

Document	Theme	Illustrative Quote	Index	Critical Analysis
SARS: *Learning from SARS – Renewal of Public Health in Canada* by NACSPH	International Considerations	"The Government of Canada should build health R&D (research and development) activities into its programs of international outreach. In particular, the new Canadian Agency for Public Health should have a mandate for greater engagement internationally in the emerging infectious disease field, and support projects to build capacity for surveillance and outbreak management in developing countries."	p. 10	○ Asserts the problematization of authority and management within an international space while framing the well-being of Canadians during public health emergencies contingent on an international presence and systems of surveillance. ○ Theme evident in sections such as "Emerging Infectious Diseases, Globalization, and Bioterrorism," "International Models," "International Aspects of SARS," "Building Capacity and Coordination: National Infectious Disease Surveillance, Outbreak Management, and Emergency Response," and "Viruses without Borders: International Aspects of SARS"
	Establishing an Emergency Public Health Authority	"The creation of an agency cannot depoliticize interactions among jurisdictions, but it can reduce the chances that the health of Canadians would inadvertently be held hostage in a jurisdictional disagreement among levels of government. Among our key recommendations therefore is that the Government of Canada create a new Canadian Agency for Public Health, led by a Chief Public Health Officer of Canada. A Canadian Agency for Public Health is arguably best structured as a Legislated Service Agency, analogous to the Canadian Food Inspection Agency, the Canadian Institutes of Health Research, or Statistics Canada. The Chief Public Health Officer of Canada would be the chief executive of the new federal agency and report directly to the federal Minister of Health."	p. 4	○ Highlights the existing political tensions and motivations of Federal and Provincial/Territorial governments and the dysfunction it produces for the argument for a new structure of authority. However, neglects the responsibility of these agencies in producing the exploitative and under resourced conditions endured by frontline workers thereby reducing the accountability of the agency. ○ Through the problematization of authority throughout the document the reader is led to the *logical* solution of a new authority for public health in Canada to address the issue framed throughout the themes. However, the proposed solution neglects to include concrete support or commitment to the needs of frontline healthcare workers. ○ This theme is reiterated throughout additional sections such as "International Models," "A New Canadian Agency for Public Health," "Federal Funding to Renew Public Health across Canada," "Public Health Partnerships Program," "National Immunization Strategy," "Enhancing the Public Health Infrastructure: A Prescription for Renewal," "Building Capacity and Coordination: National Infectious Disease Surveillance, Outbreak Management, and Emergency Response," "Strengthening the Role of Laboratories in Public Health and Public Health Emergencies," and "Some Legal and Ethical Issues Raised by SARS and Infectious Diseases in Canada"

Note: Due to the nature of the data the High-Level High Level Qualitative Analysis was restricted to the SARS data.

Table 2

Comparative Critical Policy Analysis: Quantitative Analysis of Selected Policies

		Document			
		SARS		**COVID-19**	
Topic	**Search Term**	**Frequency**	**Index** (page number)	**Frequency**	**Index** (policy code)
Personal Support Worker	Personal Support Worker	0	-	4	CAN241 ON273, ON262, ON375
	PSW	0	-	1	ON453
	Health Care Aide	0	-	0	-
	Care Aide	0	-	0	-
	Home Support Worker	0	-	0	-
	Personal Attendant	0	-	0	-
	Community Development Service Member	0	-	0	-
	Patient Service Aide	1	p. 142	0	-
	Frontline	5	p. 14, 67, 98, 117, 145	10	CAN053, CAN137 ON054, ON058, ON091, ON139, ON142, ON172, ON406, ON486
	Frontline Healthcare Worker	0	-	0	-
	Long-term Care	15	p. 9, 26, 28, 31, 41, 121, 134, 142, 143, 145, 150, 172, 181, 202, 222	40	CAN011, CAN037, CAN102, CAN103, CAN141, CAN216, CAN244 ON001, ON024, ON35, ON057, ON078, ON085, ON088, ON120, ON136, ON139, ON151, ON152, ON161, ON164, ON188, ON225, ON247, ON248, ON258, ON271, ON282, ON289, ON294, ON304, ON335, ON358, ON375, ON358, ON406, ON438, ON545, ON473, ON479
Mental Health	Mental Health	19	p. 5, 59, 69, 78, 83, 156, 156, 158, 158, 158, 158, 158, 158, 158, 158, 158, 158, 166, 172	3	CAN098, CAN113, CAN216
	Psychological	4	p. 1, 20, 179, 181	1	CAN081
	Psychosocial	9	p. vii, 11, 108, 155, 155, 187, 188, 211, 216	0	-

Table 3

Comparative Critical Policy Analysis: Qualitative Analysis of Selected Documents

		Document					
		SARS[1]			COVID-19[2]		
Topic	**Theme**	**Illustrative Quote**	**Index**	**Critical Analysis**	**Illustrative Quote**	**Index**	**Critical Analysis**
PSW	Practice Guidelines	N/A	N/A	○ No dialogue pertaining to PSW's was included throughout the document showcases their position and value within the labour hierarchy of healthcare and public health. ○ Upholds and subtly affirms the exploitation and disregard of this feminized and racialized workforce. ○ Their exclusion may have larger implications as it supports the overlooking of this group and leaving them vulnerable to be forgotten or deprioritized in future policy action.	"The government has also issued an emergency order directing long-term care employers to ensure their employees, including registered nurses, registered practical nurses, personal support workers, kitchen and cleaning staff only work in one long-term care home. This means that employees cannot work in multiple locations such as a retirement home or other health care setting."	ON 088	○ Like the FHWs experience of SARS, PSWs have been subject to a stream of inconsistent directives that impact their frontline practice and industry stability. This theme is reflective of the top-down "adaptive" yet disorganization approach employed to address PHEs. ○ The quote illustrates both the disconnect between the policymakers and FHWs as well as their naïve understanding of the PSW working conditions. This selected directive restricts PSWs, who predominantly work multiple part-time jobs due to a lack of full-time employment opportunities, working in one institution thereby reducing their income. Further the directive inadvertently understaffed the long-term care facilities while increasing the labour demand on those employed. ○ While an attempt to reduce the spread of COVID-19, the directive was not viable as it mandated a practice that reduced the resources further within an exploitative setting. ○ During SARS a need to increase *human resources* (i.e. qualified professionals) was problematized yet the framing actively neglected to consider the lack of *resources* was a lack of individuals willing or forced to work in the exploitative position. This is reflected in COVID-19 wherein PSWs are burdened with adjusting to the naïve directives while upholding a standard of care that is not reflected in the resources provided to them.

Table 3 continued

Comparative Critical Policy Analysis: Qualitative Analysis of Selected Documents

		Document					
		SARS[1]			COVID-19[2]		
Topic	**Theme**	**Illustrative Quote**	**Index**	**Critical Analysis**	**Illustrative Quote**	**Index**	**Critical Analysis**
PSW	Acquiring Critical Supplies	N/A	N/A	N/A	"Funding of $610 million for the purchase of personal protective equipment and other critical supplies."	ON 237	○ A prominent theme revolved around the purchase and acquisition of critical supplies such as PPE however, it inadvertently highlights the lack of consideration for the SARS *lesson* that indicated the need for a national supply of critical supplies in order to prepare for future public health emergencies. ○ Following SARS, the province of Ontario initially created an emergency stockpile of PPE, including masks, however, with political turnover maintaining a functional stockpile was financially de-prioritized leading to the provincial emergency supply of critical supply to be expired and not functional. Further it highlights how under resourced the frontline public health system remains. ○ PSW's remained at greater risk as the public healthcare settings were prioritized for provision of critical supplies wherein the privatized long-term care homes were tasked with acquiring their own supply of PPE.
PSW	Human Resources	N/A	N/A	N/A	"In recognition of the dedication, long hours and increased risk of working to contain the COVID-19 outbreak, the Ontario government is providing frontline staff with a temporary pandemic payment. This increase will provide four dollars per hour worked on top of existing hourly wages, regardless of the qualified employee's hourly wage…	ON 139	○ This theme is intertwined in the broader discussion of funding and capacity that was evident during SARS. ○ This directive exemplifies one of a series of temporary *pandemic pay* mandates to benefit frontline healthcare workers. Notably, due to PSWs predominantly being employed in part-time positions that are restricted to maintain employment at one facility…

Table 3 continued

Comparative Critical Policy Analysis: Qualitative Analysis of Selected Documents

		Document					
		SARS[1]			COVID-19[2]		
Topic	**Theme**	**Illustrative Quote**	**Index**	**Critical Analysis**	**Illustrative Quote**	**Index**	**Critical Analysis**
PSW	Human Resources continued	N/A	N/A	N/A	"…In addition, employees working over 100 hours per month would receive lump sum payments of $250 per month for each of the next four months. This means that eligible employees working an average of 40 hours per week would receive $3,560 in additional compensation. Those eligible to receive the payment will be staff working in long-term care homes, retirement homes, emergency shelters, supportive housing, social services congregate care settings, corrections institutions and youth justice facilities, as well as those providing home and community care and some staff in hospitals."	ON 139	○ …makes them largely ineligible for the compensation provided to workers who work over a certain number of hours. The general $4/hour increase for one part-time employee equates to an increase of $120/week or $24/day. When compared to the military operatives deployed to long-term care facilities in response to COVID-19 under Operation LASER who received standard pay and an addition of $78/day under hazard pay it becomes increasingly evident who is valued. ○ This theme is evident in policies that begin framing the lack of PSWs as an issue reminiscent of SARS problematization wherein the lack of *human resources* focused on a lack of *qualified* professionals, and not reflective of exploitative working conditions or lack of regulation (CAN241). ○ This theme and the accompanying policies begin the functional regulation of PSWs and strategically predates the announcement of a PSW regulation act entitled *Health and Supportive Care Providers **Oversight Authority** Act (Bill 283)*. The act enables the monitoring and production of labour within the PSW space providing the government increased authority while not attending to the working conditions of the PSW across the private and public healthcare sector.

Table 3 continued

Comparative Critical Policy Analysis: Qualitative Analysis of Selected Documents

		Document					
		SARS[1]			COVID-19[2]		
Topic	**Theme**	**Illustrative Quote**	**Index**	**Critical Analysis**	**Illustrative Quote**	**Index**	**Critical Analysis**
PSW	Long-term Care Setting	N/A	N/A	N/A	"The Ontario government is investing close to $540 million to protect residents, caregivers, and staff in long-term care homes from future surges and waves of COVID-19. The funding is part of the province's COVID-19 fall preparedness plan, Keeping Ontarians Safe: Preparing for Future Waves of COVID-19."	ON 271	○ The investment was a response to the increase of deaths from COVID-19 and conditions of long-term care facilities witnessed by the media and public. ○ PSW policy directives were applied through mandates directed at the long-term care setting. Upon initial consideration one may assume this is due to the fact that PSWs are predominantly employed within that space. However, it may also be reflective of the non-existent regulatory body of PSWs as applying a directive to a non-regulated labour force is both semantically and functionally impractical. This is reflective of policy interested in regulating the access and production of labour and not the working conditions. ○ This illustrative policy exemplifies how exploitative long-term care setting remains. As a predominantly private sector of healthcare in Canada it is unsurprising that it remains financially neglected as the focus functionally is healthcare profit not provision. ○ This oversight is unsurprising as it is a form of privatized healthcare and the working conditions impact PSW's a femininized, racialized, and exploited labour force and were entirely excluded from the discourse and "lessons learned" from SARS response.
Mental Health	Renewing Systems of Public Health	"The coverage of areas such as environmental health, mental health, and…"	p. 83	○ This theme is an extension of the "Limitations of Canadian Public Health Systems within PHE" (Table 1)…	"The Prime Minister, Justin Trudeau, today announced an investment of $240.5 million to develop, expand, and…"	CAN 098	○ Although necessary, the policy remains vague in commitment and action, like the SARS consideration of mental health.

Table 3 continued

Comparative Critical Policy Analysis: Qualitative Analysis of Selected Documents

		Document					
		SARS[1]			COVID-19[2]		
Topic	**Theme**	**Illustrative Quote**	**Index**	**Critical Analysis**	**Illustrative Quote**	**Index**	**Critical Analysis**
Mental Health	Renewing Systems of Public Health continued	**"…**injury prevention is clearly suboptimal and taken together, could draw an extra $30 million per annum."	p. 83	○ Throughout the discussion of public health funding, mental health is identified as a heavily underfunded sector. No financial consideration is given to the antecedents to mental health decline. ○ Although further investment into mental health is vaguely proposed no concrete commitment or action plan is outlined to address the vague issue of mental health. ○ The neglect of mental health is framed in a way so that the solution is to support the high-level priority of a new structure and authority of public health in Canada. ○ This inadvertently acknowledges mental health as a valid and established component of health at the time of SARS.	"…launch virtual care and mental health tools to support Canadians."	CAN 098	○ Neglects to consider the accessibility of such a format for the whole population including frontline healthcare workers who may be providing the care itself or are under resourced in time and ability to access the supportive healthcare. This furthers the separation of healthcare providers and those who access care ○ Focuses on mental health support and not the conditions in federal control that produce the mental health decline.
Mental Health	Regulating Access to Healthcare Services	"For medical and mental health patients, the most common route of entry to the hospital is via the ED (emergency department)"	p. 156	○ This theme is seemingly used as a tool for the document to lead the reader through practice applications of the proposed narrative. The term *mental health* is most extensively used in discussion of hospitalization due to mental health and not in relation to the broader public's mental health concerns or vulnerabilities.	"Future flights are planned for May 20, June 3 and June 17 to fly-in communities in Ontario, Manitoba and Alberta for nurses, as well as other health care providers such as doctors and mental health service providers. Flights will then continue every four weeks until it is safe to return to the previous process. Other flights may be scheduled to bring cargo or…"	CAN 113	○ Similar to SARS, this exemplifies a tool used to further the construction of a narrative within COVID-19. While the illustrative quote details the decision to deployed human resources to remote communities in Ontario it frames it as a function of accessing care, yet it is predominantly a military operation. This particular directive enables the policing of remote communities, which are largely comprised of First Nations and…

Table 3 continued

Comparative Critical Policy Analysis: Qualitative Analysis of Selected Documents

		Document					
		SARS[1]			COVID-19[2]		
Topic	**Theme**	**Illustrative Quote**	**Index**	**Critical Analysis**	**Illustrative Quote**	**Index**	**Critical Analysis**
Mental Health	Regulating Access to Healthcare Services continued	"For medical and mental health patients, the most common route of entry to the hospital is via the ED (emergency department)"	p. 156	○ Enables the framing of mental health as a concern only in the space of hospitalization and not extended in the public or labour space further separating the provider of care from the access of care.	"…other critical personnel such as professionals needed to maintain or fix critical infrastructure if additional needs are identified."	CAN 113	○ Indigenous groups, in order to assert authority within a PHE. ○ It neglects to ensure that deployed *critical personnel* are both culturally informed and adequately resourced to attend to the needs of the communities. Further it frames the provision of care as an issue of access and not quality
Mental Health	*Psychological* Considerations	"Health care workers caring for SARS patients were at heightened risk for contracting a new and dangerous disease and worked under physical and psychological stress."	p. 1	○ A subtle yet critical distinction is made throughout the document between *mental health* and *psychological/psychosocial*. Although both convey a similar experience of adverse mental health outcomes, when in relation to FHWs the experience is only framed as *psychological implications* or *psychological stress* throughout the document. By contrast, the document acknowledges *mental health* as an experience and extension of health only as it pertains to hospital services or public health structures. This semantic choice was arguably intentional in order to reduce the perception of severity of the FHW mental health experience in addition to reducing the link between the FHW mental health outcomes and the discussion of how under resourced the workplace setting and mental health services are within Canada…	N/A	N/A	N/A

Table 3 continued

Comparative Critical Policy Analysis: Qualitative Analysis of Selected Documents

		Document					
		SARS[1]			COVID-19[2]		
Topic	**Theme**	**Illustrative Quote**	**Index**	**Critical Analysis**	**Illustrative Quote**	**Index**	**Critical Analysis**
Mental Health	*Psychological* Considerations continued	"Health care workers caring for SARS patients were at heightened risk for contracting a new and dangerous disease and worked under physical and psychological stress."	p. 1	○ …This establishes a need to attend to the heightened mental health risk of the public however, maintains the problematization as *psychological implications* not mental health and relies on frontline workers thereby neglects their expressed needs.	N/A	N/A	N/A

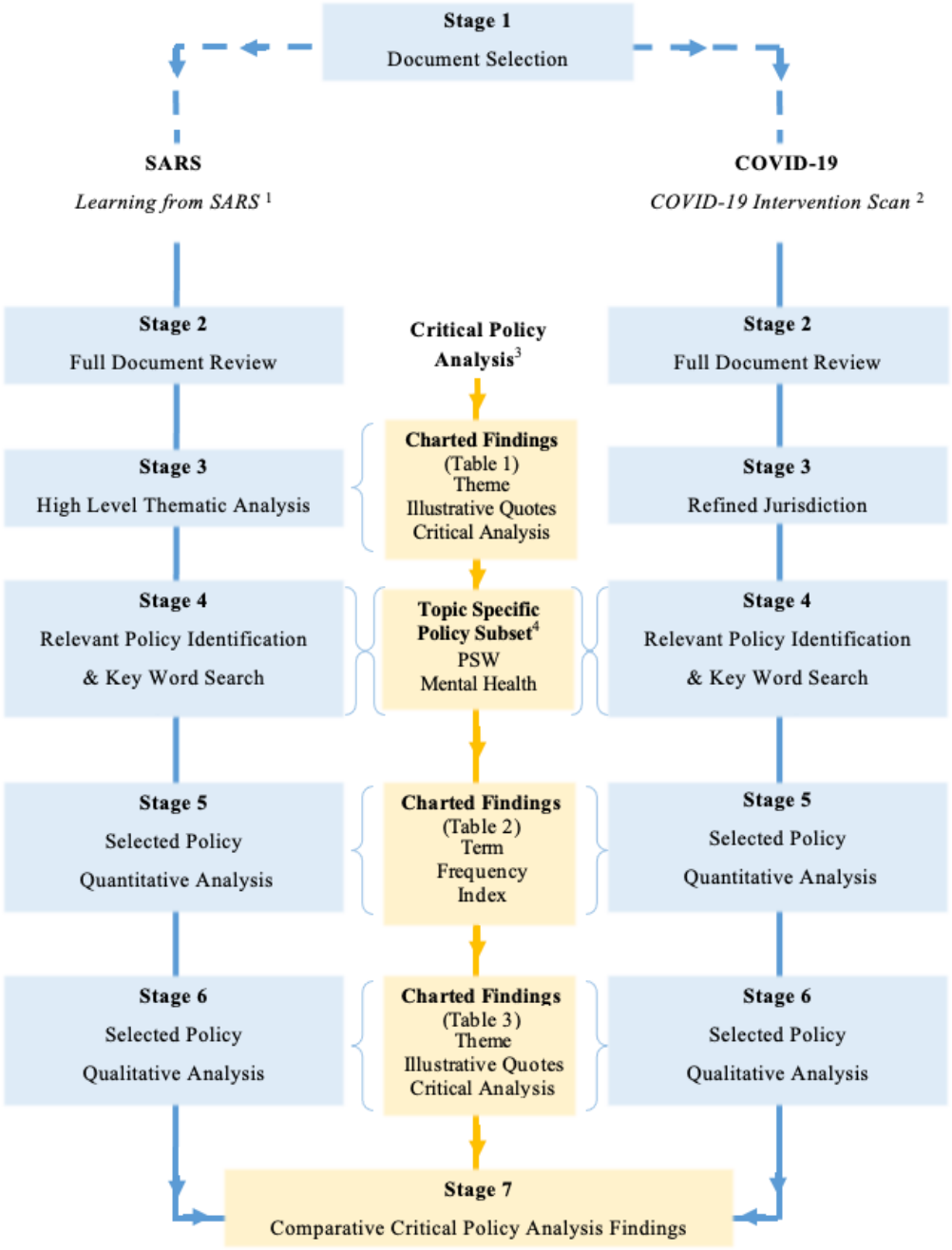
Note:

[1] *Learning from SARS – Renewal of Public Health in Canada* by NACSPH

[2] *COVID-19 Intervention Scan* by CIHI

Figure 1

Research Approach Flow Chart



Note. *Description*

[1] *Learning from SARS – Renewal of Public Health in Canada* by NACSPH.

[2] *COVID-19 Intervention Scan* by CIHI.

[3] Critical policy analysis informed by document analysis, critical comparative policy analysis, thematic analysis, and critical discourse analysis as detailed in the methodological considerations.

[4] Subset includes "Personal Support Worker," "PSW," "Health Care Aide," "Care Aide," "Home Support Worker," "Personal Attendant," "Community Development Service Member," "Patient Service Aide," "Frontline," "Frontline Healthcare Worker," "Long-Term Care," "Mental Health," "Psychosocial," and "Psychological"

Figure 2

Visualization of Quantitative Analysis of Selected Policies Findings