Ontario Health Coalition

REPORT

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Submission to the SARS Commission

November 18, 2003

The Ontario Health Coalition is comprised of over 400 member organizations, 78 local coalitions and thousands of individual members. Our primary goal is to empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to health care and healthy communities. To this end, we seek to provide to member organizations and the broader public ongoing information about their health care system and its programs and services. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential for good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information. We are a non-partisan group committed to maintaining and enhancing our publicly-funded, publicly-administered health care system. We work to honour and strengthen the principles of the Canada Health Act.

Our members include local health action committees; women's groups such as the National Action Committee on the Status of Women, the Older Women's Network, Canadian Pensioners Concerned, Immigrant Women's Health Centre, Voices of Positive Women; seniors' groups including the Ontario Coalition of Senior Citizens Organizations, CAW retirees, Alliance of Seniors to Protect Social Programs; low income and homeless peoples' organizations including Low Income Families Together, Food Share of Metro Toronto, Ontario Coalition Against Poverty; health sector unions such as CUPE, ONA, OPSEU, SEIU, USWA, UFCW and CAW; service providers; social service organizations; community health centres; workers' advocacy organizations; health professional associations; ethnic and multiracial minorities; the Ontario Federation of Labour; and other organizations such as the Canadian Council of South Asian Seniors (Ont.), Care Watch, Concerned Friends of Ontarians in Long Term Care Facilities, Ontario Coalition for Social Justice, Medical Reform Group, Social Planning Council of Metro Toronto, Native Women's Resource Centre, Aids Action Now, Birth Control and Venereal Disease Information Centre, the Canadian Federation of Students (Ontario division), Oxfam Canada and the Injured Workers Resource Centre, among others. We are linked to the Canadian Health Coalition and provide provincial coordination of community-based health coalitions.

Along with many others, we watched the progress of the SARS outbreak with horror. Although much of our submission is of a technical nature relating to the broad impacts of policy decisions and interactions within the health system, we do not forget that this was foremost a profoundly tragic human experience. Our first thoughts are for the families of those patients and health care workers affected.

We are aware that many of the organizations and individuals making submissions will discuss the finer points of communication and confusion within the health system. We will not duplicate their efforts. Instead, we will focus on several policy trends that have had and will have direct bearing on our health system's ability to respond in the most efficient and humane way to such an outbreak. We will make recommendations with respect to those policy decisions that relate to the capacity, resources and control of our hospitals, and to their culture. There are some issues for which we do not have answers, but we do have questions into which we hope this Commission will probe.

There are several clear lessons that we hope your Commission will draw from the SARS outbreak. The deep cuts to the hospital system in the mid-1990s and the downloading of public health onto municipalities has had lasting effects on the system's ability to deal effectively with crises. These cuts have led to record hospital deficits, instability, casualization of the healthcare workforce, inadequate bed and staffing levels, an outdated and underfunded public health system, and inability to control the spread of infection. More recent increases in funding are disproportionately going to salaried or management in hospitals, rather than waged nurses, healthcare workers and support services. The trends towards separation of so-called "clinical" and "non-clinical" services and privatization of services within hospitals and other institutions bodes ill for improved containment in the future. In addition, the lack of democracy and institutionalized hierarchies within hospitals meant that warnings and cautions that should have been heeded were ignored.

Cuts, Inadequate Capacity & Instability

In the mid 1990s, approximately $800 million was cut from hospital budgets, with little warning and inadequate planning. Funding instability has not only caused deep cuts to services, it has also created new monetary and other costs. The cuts and restructuring have combined to create grave inefficiencies and redirection of precious resources from patient care to administration, capital costs, consulting fees, and others. Non-monetary costs such as demoralization of staff, increased stress, accidents, injuries and staffing shortages are increasing. Insecure budgets have diminished the ability of facilities to hire permanent full-time staff and to create working conditions to attract and retain personnel. In Ontario, literally hundreds of millions were spent on consultants and restructuring to reduce patient length of stay, lay off staff and close hospital beds. Then, ironically, millions more were spent on trying to hire back staff and reopen hospital beds. The former provincial government regularly used hospital re-funding as a public relations exercise, delaying and stretching out announcements to maximize public exposure, and routinely re-announcing monies that had been previously announced. The results of these policies have lasted longer than the cuts themselves.

Our hospital system is scarred by years of record level operating deficits and late budget announcements. This instability in funding has sent shock-waves of instability through the hospital workforce. From 1995-1999, according to a study by the Canadian Union of Public Employees, approximately 25,000 hospital workers' positions, including those of nurses, were cut. Unstable and unpredictable hospital budgets, combined with management trends, have led to the increasing casualization of hospital labour - nurses, health professionals and support staff. This, in turn, has meant that many must work in more than one facility to make a living. The movement of workers from facility to facility provides an opportunity for the spread of infection, as was experienced in the SARS outbreak. Serious shortages in the midst of crisis were the result, as nurses and others were not allowed to move from facility to facility during the outbreak.

The re-funding of hospitals in recent years has not been met with an equal distribution of the income. Statistics Canada figures show that: by 1999, hospital and long term care staffing levels had *dropped* by nearly 10% while operating spending was *up* by nearly 10%. Despite a population growth of approximately 750,000, hospital and long term care staffing numbers have

plummeted. In March 1995, there were 26 hospital and long term care staff for each 1,000 Ontarians. In 2000, this figure had dropped to just over 22 staff per 1000.

The costs of overworked staff have become evident. A major study by the Canadian Medical Association Journal indicates that reported errors had increased significantly between 1992 and 1997. Misadventures rose from 18 to 30 per 10,000 for in-patients and 5.2 to 11.6 for day surgeries. Complications rose from 330 to 500 per 10,000 for in-patients and from 65.2 to 95.1 per 10,000 for day surgeries. Adverse drug reactions rose from 104 to 162 per 10,000 for in-patients and from 8.1 to 10.8 for day surgeries. An Ontario Hospital Association commissioned study reported that the cut of 4,000 nurses between 1994 and 1999 resulted in reduced patient supervision and less nursing time, lower levels of cleanliness and increased staff stress.

A second effect of the hospital restructuring and cuts of the mid-1990s was a too steep reduction in hospital beds and a concurrent crisis in emergency care. An early and tragic warning about the impact of hospital bed closures was made all-too-clear in the death of Joshua Fleuelling who died in an ambulance unable to get a timely spot in an emergency room. In Joshua's case, the coronor's inquest recommended that closed hospital beds be re-opened and full-time positions be increased to ease the pressure on emergency rooms and prevent reoccurrence of such a horrible loss. These recommendations mirrored those of a coroner's jury into the death of Kyle Martyn in 1998. Last year, in response to the Ontario Hospital Association's annual hospital report card, the former CEO of one of the SARS-affected hospitals defended his hospital's report card rating by noting that patients were unlikely to rate a hospital highly if they had spent hours and hours waiting in emergency or in hallways for beds. One of the sites of SARS spread was at the Scarborough Grace emergency department in which one SARS patient lay for 12 hours beside an elderly gentleman who then contracted the virus. The second patient went on to infect his wife and both died. At the time it was reported that hospital staff believed that the first patient was infected with tuberculosis, an infectious disease. One of our questions is whether the proper protocols were followed in this case, and if so, are they adequate? If not, why were they not followed - are bed and staff shortages part of the cause - and how can such a tragedy be avoided in the future? Why were patients waiting for more than 12 hours in emergency wards?

We note that as hospital restructuring starts to unravel across Ontario, one of the results is that communities that were slated to lose hospital emergency rooms will keep them open. In some cities, for example, Kingston Ontario, this means that the community will continue to have access to a second ER in the event that one hospital is closed or limited due to an infection such as SARS. The same applies to hospital clinics. Between 1989 and 1998, 64 Ontario hospitals were merged or closed outright, reducing the total number of hospitals in the province from 262 to 198. We hope that your Commission will look into the impacts on infection-control and access to hospital clinics and other services in emergency situations of centralizing community hospitals into one site.

In addition to the hospital cuts, the downloading of public health budgets onto overstretched municipalities also impacted the ability of the system to cope with a crisis. Toronto public health relied upon an outdated paper tracking system, inadequate staff and inadequate resources to deal with this crisis. We have received reports that vital public health functions were not possible to carry out during the SARS outbreaks because of the shortage of staff and resources. Some programs remained closed for months after the outbreaks were contained, to make up savings in public health budgets.

Inadequate Democracy & Institutionalized Hierarchy

The entrenched hierarchies and lack of democracy within hospitals has stifled the institutions' abilities to respond most effectively to crises. The inequality of the distribution of the re-funding in the hospital system is a reflection of the current culture and hierarchy within these institutions.

Most notably, the second outbreak of SARS in Toronto was noticed by nurses who warned their superiors but were not heeded. Complaints about ill-fitting or inadequate equipment from support staff and nurses were addressed slowly, if at all. There are few democratic protections for staff in hospitals: contracts that include gag orders, no whistle-blower protection, inadequate opportunities to participate in decision-making that affects workers' and patients' lives. Hospitals themselves are run with little democracy and inadequate transparency and public scrutiny.

Emerging Policy Directions

One of the disturbing trends in Ontario's hospitals is redevelopment using the "P3" or public private -partnership model in which the ownership and operation of the hospital are privatized. We are concerned that P3 hospitals would have less ability to deal effectively with a crisis such as SARS due to the structure and mandate of the organizations involved. P3 hospitals contain two separate managements - one for the privatized building and so-called non-clinical services and one for the non-profit clinical services. Differences must be negotiated out between these two structures who do not always co-exist collegially. In a Halifax school P3 for example, children were still drinking bottled water a year after arsenic was found in the school water system. The for-profit consortia and the schoolboard were in a prolonged fight about who would have to pay to fix the water system. We believe it is dangerous to hand over the ownership and operation of critical hospital services to for-profit corporations whose mandate is to maximize profits. In a SARS outbreak, for example, we question whether the profit motive would interfere with adequate health & safety protections, proper equipment, supplies and staffing levels, quick response to government directives etc.

The privatization of support services - within or separate from the P3 model - poses a similar problem. The efficiences that private corporations find in order to reduce costs and make room for profit-taking include staff cuts and cuts to quality of equipment and services. We have already noted the impact of casualized inadequately paid staff in our hospital system. Inspections of Britain's new P3 hospitals have found high rates of ward closures and quarantines due to infections. The Royal College of Nurses in Britain last year noted a strong correlation between privatized cleaning services in hospitals and increased infection rates. A similar correlation was noted in Taiwan by the Director at the Centre for Disease Control in response to their SARS outbreak.

We have several conclusions & questions:

1. Restoration of hospital funding must be accompanied with human resources planning geared to increasing the number of front-line service and nursing staff. Inequalities in the distribution of new funding should be tracked and addressed.

2. Other jurisdictions that are copying Ontario's experiment with deep and sudden cuts to hospital systems should take heed that the instability caused by such cuts does not save money, but leads to increased costs and consequences that long outlast the cuts themselves.

3. There has been more than sufficient warning that long emergency room waits are a tragedy in waiting. Hospital bed and staffing levels must be such that these long waits are eliminated.

4. Hospitals need stable funding that allows them to plan ahead. They must develop human resources recruitment and retainment strategies that reverse the casualization of the hospital workforce.

5. The policy of centralization of hospitals needs to be reviewed in light of infection control and access to services in crises such as the SARS outbreak.

6. Are infection-control protocols in emergency rooms adequate and are they able to be followed in light of the resources hospitals currently have available to them?

7. The trend towards privatization of support services in hospitals should be stopped. The false distinction between "clinical" and "non-clinical" services must be recognized as a false dichotomy that supports hospital hierarchies but does not accurately reflect the importance of the work of support and service staff to patient care and infection control.

8. Steps must be taken to reduce the ill effects of the entrenched hierarchies within hospitals. Whistleblower protection for staff and meaningful opportunities for staff participation in workplace committees and decision-making affecting themselves and their patients would begin to improve this.

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