Submission to the Standing Committee on Finance & Economic Affairs

A submission to the Ontario Ministry of Labour Standing Committee on Finance and Economic Affairs, from the Ontario Public Service Employees Union, Hospital Support Division

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Introduction: Hospital support workers, key partners in health

OPSEU represents approximately 3,652 members that provide hospital support services across Ontario in 20 public hospitals.

Hospital support workers ensure that facilities function efficiently and assist the public with navigating and accessing health services. Without them, hospitals could not operate.

The range of functions performed by skilled support workers is broad and reflects the complexity involved in running 24-hour healthcare facilities. Jobs include: porter, groundskeeper, cleaner, ward clerk, information technology printer, cook, receiver, switchboard attendant, registered practical nurse (RPN), emergency room attendant, health records clerk, admitting clerk, electrician, plumber, technician, laundry operator, maintenance worker, carpenter, dietary and physiotherapy aide, painter, mechanic, accounting clerk, operating room technician, and sterilization technician.

Without the proper paperwork or supplies, surgeries would have to be cancelled. Without accurate information in the medical record, patients could be put at risk. Without porters to move people and material about the hospital, the facility would grind to a halt. Without cleaners, the risk of hospital-borne infections would grow. Without the proper organization of critical testing and imaging, surgical supplies, and operating room preparation, our patients could be at risk. In other words, hospital support workers are not optional.

Clerical workers often provide the first point of contact. Patient satisfaction is often shaped by the quality of interaction with clerical staff in the "circle of care" model of hospital health provision. Behind the scenes they offer invaluable assistance with navigating hospital services, ensuring that patients are scheduled for their testing or other specialized appointments, and maintaining current accurate health records.

The role of Registered Practical Nurses (RPNs) in the healthcare system has dramatically expanded by 52.3 per cent since 2005, and in 2014 increased by 5.6 per cent. Ontario has not kept pace with other provinces. Canada as a whole now has about 21 per cent more practical nurses working in hospitals per capita than Ontario does. [1]

Housekeeping staff and sterilization technicians (CSR) workers are the hospitals' first defense in infection control. Hospitals have rigorous inspection mechanisms that minimize the risk of infection. The profit motive incentivizes cutting corners; evidence has shown that hospitals that directly employ and manage housekeeping staff have better track records with infection control. A 2008 report published by the Hospital Employees' Union in B.C. found that privatization led to high staff turnover and a dramatic reduction in the amount of time cleaners spent at health-care facilities. A study published in the Journal of Hospital Infection found that

a stubborn MRSA outbreak at a hospital in Britain was only contained after the number of hours cleaners spent on the ward was doubled from 60 to 120 each week. The new trend to outsource hospital cleaning services overlooks just how important cleaners are to healthcare. Hugh MacLeod, chief executive officer of the Canadian Patient Safety Institute, identified cleaners as an important part of a continuum of care and admitted that unfortunately not all institutions view cleaning services as critical when looking for cost savings.[2]

Chronic hospital underfunding

Underfunding and overcrowding in Ontario hospitals continues to place tremendous pressure on hospitals to find savings which often target the less visible but critical aspects of the hospital workforce.

Most recently, the CEO of the Ontario Hospital Association, Anthony Dale, said that, "after four years without an increase in base operating funding, hospitals are now at a turning point. Hospitals are facing extremely challenging budget decisions aimed at containing costs while meeting the increasing service needs of patients."[3]

In 2015, the Ontario Health Coalition published *"Code Red: Ontario's Hospital Cuts Crisis,"* warning that Ontario's hospitals are living in a permanent state of crisis, having been pushed by years of cuts into levels of overcrowding that are dangerous for patients and staff. The report identified 51 hospital sites slated for significant hospital cuts or the threat of closure.

The report highlighted that Ontario is in its eighth year of real-dollar cuts to hospital global budgets. For the last three years, hospital global budgets have been frozen at 0 per cent increases, which is in real-dollar terms a significant cut. After decades of downsizing, the cuts are biting ever more deeply into vital patient care services.

Key findings of the report include:

- Many hospitals in larger communities are operating at 100 per cent capacity. Patients are lined up in stretchers in hallways. This puts hospitals into what is called "code gridlock" and staff are forced to discharge patients ever "quicker and sicker" to free up beds.
- Internationally, the accepted evidence shows that a safe level of hospital occupancy is between 80 and 85 per cent. Anything higher than this leads to higher rates of potentially fatal hospital-acquired infections, bed crises, backlogged and overcrowded emergency departments, patients in stretchers in hallways, inadequate clinical staff for

patient load, long waits, ambulance offload delays, and a host of other problems. These problems are frequently seen in Ontario's larger towns.

- Small and rural hospitals have faced disproportionate cuts and a number are at risk of total closure, despite overwhelming community opposition and dangers to patients.
- Excuses such as "transforming health care," "moving care to the community," and blaming the bed shortage on Alternate Level of Care patients are simply cover for real hospital cuts to services that are not being - and cannot be -- transferred to public health care services in the community. Too often, these are just cover for privatization of needed health care.
- Ontario funds its hospitals at the lowest rate per capita of any province in Canada.
- Ontario has the fewest hospital beds left of any province in Canada and is near the bottom of the entire OECD in the number of hospital beds per population.
- For the true measure of affordability -- hospital funding as a proportion of our provincial GDP -- Ontario ranks nearly at the bottom of the country. We are 8th of 10 provinces.[4]

Downloading to community for-profit clinics (Independent Health Facilities)

The growing trend to download services to for-profit clinics poses risks to patients. In 2014, Ontario brought in regulations making it easier to outsource community hospital services to private clinics (Independent Health Facilities) with an initial focus on providing low-risk cataract and colonoscopy services. Government has indicated that in the future, additional procedures that do not require overnight stays in a hospital will be eligible to be performed in Specialty Clinics. The introduction of the profit-motive in health care will undoubtedly impact on quality as 97 per cent of IHFs are run by for-profit companies.

The Toronto Star in an investigative report cited that three Toronto colonoscopy clinics had hepatitis C outbreaks since 2011 and nine patients contracted a life-threatening bacterial infection at a Toronto pain clinic in 2012. A confidential investigation revealed that stoppers had not been wiped down properly. [5]

In 2011, Ottawa Public Health announced that about 6,800 people had been sent registered letters informing them that there was a tiny risk that patients may have been exposed to hepatitis or HIV after undergoing procedures at a "non-hospital" clinic. The clinic had not always followed infection prevention and cleaning protocols for endoscopic equipment. Douglas Angus, a health economist and professor at the University of Ottawa's school of management, pointed out that "when you get into the private clinics and facilities of that nature, it appears we don't have the same kind of oversight and regulatory environment as hospitals."[6]

The College of Physicians and Surgeons of Ontario is the regulator of IHFs and has not provided adequate inspection of these facilities as confirmed by the Auditor General in a 2012 report. As of March 2012, almost 60 per cent of the independent health facilities had not been assessed within the prescribed time frames. Furthermore, the Ministry could not determine how many of these facilities were new or how many had been rated as "bad" in their last inspection.[7]

The impact of underfunding on hospital support services in Alliston, Kingston and Orillia

The **Stevenson Memorial Hospital** in Barrie is operating at capacity, and with a growing population the hospital is gambling with patient care. The lack of beds is so acute that hallway admissions are a daily occurrence, and patients are held in overflow areas in the emergency department.

Levels of overcrowding pose health risks. Services staff at the hospital have reported higher levels of overwork and illness. Just this past month, the hospital declared an outbreak of the illness after five cases of C. difficile in January 2016.[8] A study published in the American Journal of Infection Control, by Dr. Dick Zoutman, Queen's University, confirmed that overcrowding raises risk of infection. Researchers found that each new roommate raised a patient's risk of picking up an infection in hospital by about 10 per cent.[9]

The current emergency department at Stevenson Memorial Hospital (SMH) was built in 1964 to accommodate 7,000 visits. Today the hospital experiences in excess of 33,000 visits annually. In 2014 the hospital made a pre-capital submission to the LHIN for a redevelopment project. In 2015 the hospital made a pre-capital submission to the MHLTC, proposing a $123 million dollar capital expansion for a new facility. The total gross square footage of the new facility would be 161,577, more than twice the current size of 71,925. The proposed facility if approved would be scheduled to begin construction in 2018.[10]

In Orillia, the **Soldiers' Memorial Hospital** has made up funding shortfalls by making cuts to staff, beds and other vital services. In 2012, the hospital closed five surgical beds and two pediatric beds. In 2013, more than 60 support and administrative staff positions were cut and more than 20 beds were closed, resulting in additional layoffs of medical personnel. The hospital moved to cap the volume of certain procedures based on available government funding, including temporarily reducing the number of operating rooms from four to three for the final quarter of the fiscal year ending in March 2014.[11]

In 2015, projected cuts continued. The hospital announced that it planned to eliminate 20 full-time-equivalent positions as part of it latest operating budget, citing the province's ongoing funding freeze and the need to eliminate its debt as the primary reasons for the cuts. The emergency department is continuously backed up. Medical units are creating unfunded beds to respond to higher patient usage, placing tremendous pressure on staff. The Continuing Complex Care (CCC) unit is reducing beds to accommodate medical patients during "surge" periods. [12]

Hotel Dieu, as part of University Hospitals Kingston Foundation, submitted a joint proposal to the local city council in 2015. The Foundation requested $100,000 from the city over four years, starting in 2016, to fund the hospitals' "highest priority needs." The councilors identified that "the real problem here is a municipality funding health care at all."[13] The gap between demand and access is growing and will continue to grow. The provincial government's move to centralize and share services in rural areas will continue to place a strain on the larger urban hospitals and will force patients to travel more frequently for specialized care such as cancer treatment. The implementation of central scheduling will require patients to travel further for diagnostic imaging appointments as they can be referred to any one of the five hospitals in the geographic area.

In 2014, Hotel Dieu reduced its hours from 14 to 12 at its Urgent Care Centre. This has placed greater strain on the emergency department at Kingston General Hospital (KGH) which was on code gridlock for 25 days last October - November. The province's strategy to increase "after hours" access to alternate community-based care is undermined by cost-saving practices that reduce access to non-emergency care. Wait times for the KGH are between 6-18 hours.[14]

Concerns have been expressed by the support workers about the hospital's intent to outsource the management of the facilities department (housekeeping, porters, switchboard, and print shop). Contracting out cleaning services to the lowest bidder is a short-sighted approach. While there isn't an absolute relationship between outsourcing hospital cleaning services and higher rates of infection, when housekeeping is done on a for-profit basis, employers will reduce the number of staff and cut corners on staff training and cleaning supplies. In Scotland four years ago, health authorities reversed their decision to allow outsourcing of cleaning and catering services because they felt private contractors were not doing a good enough job keeping the spread of infections in check.[15]

Patient Satisfaction: local fresh food procurement

Hospital support workers are often the first services targeted for cuts and outsourcing. They are not considered to be priority in the hierarchy of service provision and yet their work holds up the infrastructure of the hospital and directly impacts on patient satisfaction.

Freshly made, nutritional hospital food plays a role in the healing process and patient satisfaction. Hospitals that have replaced rethermalized industrial food with freshly made food cite reduced amount of food waste, better nutrition, and dramatically increased patient satisfaction. This was the experience at St. Joseph's Health Centre in Guelph. In 2012, the hospital introduced home-style meals and saw patient satisfaction increase to 87 per cent. It also had a significant positive impact on staff morale.[16]

In 2013 the provincial government passed the Local Food Act (2013), legislation that mandates increasing local food procurement in the broader public sector, including at hospitals and nursing homes. More and more hospitals are replacing real food with factory food (retherm food) cooked in distant locations and shipped in over the highways. If the government is serious about improving the quality of hospital food it needs to put policies in place that will support local procurement and encourage hospital to produce freshly made meals.[17]

Recommendations

Chronic underfunding of hospitals will not improve the delivery of acute care services. Hospitals face impossible decisions in deciding which service will be cut, to the detriment of all Ontarians. Hospital support workers are the backbone of hospitals and should be considered as key partners in delivering 21st century medicine.

1) Stop the cuts to public hospital services. The new provincial funding formula has created havoc in hospitals, especially in rural areas.
2) Continue to increase the number of RPNs in hospitals. The government has recognized the significant role that RPNs can play in health care delivery but still lags behind other provinces.
3) Stop the expansion of private clinics (IHFs) and uphold the Canada Health Act's prohibition on extra-billing and user fees. The lack of adequate oversight of these clinics continues to pose a risk to public health.
4) Prevent the contracting out of all hospital support worker positions.
5) Create the necessary regulations facilitating implementation of the government's Local Food Act (Bill 36). Few hospitals provide fresh local food. The government needs to make this a requirement, not an option.

Notes

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