



# Do comparisons between hospital support workers and hospitality workers make sense?

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Professor Cohen has served on several boards and commissions in British Columbia including, B.C. Task Force on Bank Mergers; the B.C. Industrial Inquiry Commission on the Fisheries; Board of Directors of B.C. Hydro; Board of Directors of B.C. Power Exchange. She is an activist who has served on the executive boards of the National Action Committee on the Status of Women, the Coalition Against Free Trade and the Canadian Centre for Policy Alternatives. She was also instrumental in establishing the Canadian Centre for Policy Alternatives in B.C. and was its first Chair.

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# Executive Summary

**T**HIS PAPER CHALLENGES THE ASSUMPTION that privatizing hospital support work would save the health care system money. Those in British Columbia who argue that money would be saved if health care facilities focused on direct care medical services and contracted out “ancillary” “hotel-like” services to private firms frequently base their claims on a three-page Fraser Institute report that compares the work of health care support workers to hotel workers to prove their case.

The first part of this analysis examines the methods used in the Fraser Institute report. It shows that the savings it claims are possible through paying hospital support workers the same as hotel workers are based on faulty research, heroic assumptions, and extrapolations that exaggerate the wage differentials between these two sets of workers.

But the major problem with the Fraser Institute claim is that it does not examine the actual work of hospital support workers to determine whether this work is comparable to the work done in hotels.

In order to address this omission, the second part of the study examines the distinct skills, responsibilities, and working conditions of hospital housekeeping staff, laundry workers, trades persons, food, and clerical workers. It shows that the technical sophistication of hospitals and the responsibilities of support workers require a different set of skills and training than would be required in a hotel.

These skills are health care specific and are usually acquired through a long-term association with hospital work; something that is supported by the wages, benefits and job security provisions of the collective agreements covering 60,000 health and support workers in hospitals, long-term care facilities and community health services in B.C.

Health care support workers have considerable contact with patients/residents. This association with patients/residents brings challenges and risks that are unique to a health care setting. The study shows, for example, how contact with chemicals and body substances makes the work of many support workers in hospitals and long-term care facilities considerably more hazardous than that experienced by similarly titled workers in hospitality and other work places.

The main point of this analysis is that the level of skills, responsibilities and working conditions of support workers are significantly different from those of workers in the hotel sector. These differences, combined with the health care specific on-the-job experience and training required, provide the basis for the higher wages for support staff in the health care sector.

The third section of this study examines experiences with the contracting out of hospital support work in the U.S. and at the Toronto Hospital. The aim is to assess whether privatizing these so-called “hotel” services results in lower costs while maintaining the quality of existing service. Although U.S. hospitals have gone further than those in Canada in privatizing or

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**‘Fraser Institute claims are based on faulty research and exaggerate wage differentials’**

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“re-engineering” the provision of support services, the extent this has occurred is exaggerated by those who advocate privatizing these services in B.C.

However, among those U.S. hospitals that have embarked on “re-engineering,” the expected benefits in lower costs frequently do not occur. In fact, institutions like the American Hospital Association caution about the probability of increased costs and reduced reliability of performance through hospital re-engineering and privatization.

Similarly, an examination of the experience of the Toronto Hospital (part of the University Hospital network) with contracting out food services and stores indicate that the promised benefits from outsourcing have not been achieved. The recent reversal on contracting out food services indicates the degree of dissatisfaction with this experience by both patients and staff. In general, surveys conducted by hospital management indicate that there is an unusually high degree of staff and patient dissatisfaction with the hospital – a dissatisfaction that can be correlated to the re-engineering that occurred.

In the fourth section, this paper shows that the advocates of privatizing support services in health care facilities have a larger target – that is, the privatization of hospitals themselves. Evidence from the U.S. shows that hospital privatization leads to greater costs and lower efficiencies, with the greater costs coming partially from the provision of more expensive “hotel services.”

The study concludes by pointing out that the rush to privatize too often occurs when the empirical evidence points in the opposite direction. The hidden costs of privatization to both patient health and staff morale should make administrators extremely wary of calls for privatizing hospital services. Since the current direction of health care reform indicates an increasing awareness of the integrated nature of patient care, it would be wrong, through privatization, to split clinical and non-clinical health care work as though they are disconnected. Privatization of any part of the health care system will fragment care and place barriers in the way of teamwork and collaboration.

# I. Introduction

**T**HIS PAPER IS A RESPONSE TO RECENT CALLS for alleviating the funding crisis in health care by limiting public expenditures to direct patient care services. Proponents of this view argue that money can be saved if health care facilities focus exclusively on direct patient care, and contract out so-called “ancillary” or “hospitality” services. The assumption is that labour costs for service workers in private firms are lower than in the health care system. The savings from contracting out support work, it is argued, would free up resources to meet the shortfall in funding for physicians, nurses and other direct care staff.

In B.C., very influential people have taken up this argument. Vaughan Palmer, political columnist for the *Vancouver Sun*, for example, blames the wages paid to “nonprofessional” health care workers for a situation that deliberately “starved the acute care portion of the health care system of resources.”<sup>1</sup> Similarly, former British Columbia Medical Association President Ian Courtice targets unionized “nonessential” health care workers for driving up hospital costs and calls for the privatization of this work.<sup>2</sup> And Fred McMahon of the Fraser Institute claims that unionized hospital workers who are not health care professionals earn 10 to 20 per cent more than people doing the same job in the private sector.<sup>3</sup> McMahon’s claim is based on an earlier Fraser Institute paper that is worth examining because its assertions are repeated frequently enough to have acquired some status as a genuine study.

The Fraser Institute “study” on labour costs in the hospital sector is a slim, three-page 1995 report produced by Cynthia Ramsay.<sup>4</sup> In it the Fraser Institute estimates that B.C. could save \$198 million a year, or 6.8 per cent of the total annual spending at the time on acute care hospitals in the province if “non-technical” hospital workers were paid wages equal to their private sector counterparts.<sup>4</sup> While the Fraser Institute piece does not spell out the method by which the wages of these workers would be decreased, the two main possibilities for achieving this savings would be through wage rollbacks and/or privatization through contracting out non direct care services.

This report will initially examine the methodology of the Fraser Institute report to understand the validity of its claims. This will be followed by a detailed examination of the nature of support work within health care facilities, work that the Fraser Institute considers comparable to support work in hotels. The main point of this analysis is to determine if the work in the two workplaces is, in fact, the same or similar.

The paper will also discuss the broader implications of privatization of “hotel-like” hospital services based on the experiences that have been documented in the literature and through information obtained in interviews and documents from Toronto Hospital, part of Canada’s largest health care facility, the University Hospital Network. The Toronto Hospital’s experience has been included because it is one of the most prestigious teaching hospitals in Canada and has positioned itself as a leader in providing alternate delivery strategies through re-engineering, outsourcing and contracting out.

<sup>1</sup> Vaughan Palmer, “NDP Policies Depleted the Health System,” *The Vancouver Sun*, 4 November 2000.

<sup>2</sup> “Redistribute Funds and Privatize Non-Essential Services, Says BCMA President,” *Sounding Board Vancouver*, 29 February 2000.

<sup>3</sup> Fred McMahon, “Doctor Problem,” *The Vancouver Sun*, 15 January 2001.

<sup>4</sup> Cynthia Ramsay, “Labour Costs in the Hospital Sector,” *Fraser Forum* (November 1995): 17.

## II. The Fraser Institute study: cost saving claims don't measure up

**I**N 1995 CYNTHIA RAMSAY PRODUCED a very simple study that examined the wage rates paid to 17 specific Hospital Employees' Union jobs at Royal Columbian Hospital in New Westminster using negotiated collective agreement wage rates at April 1, 1995. She compared these to "similar" jobs and wage rates for Hotel Restaurant and Culinary Employees (Local 40) hotel workers outlined in that union's Nov. 1, 1991 collective agreement.<sup>5</sup>

According to the comparison of jobs deemed to be equivalent to those in hotels, Ms. Ramsay concluded that if this hospital paid the same rates as those earned by unionized hotel workers it would save more than \$2.6 million a year.

This comparison covered only 372 of the 776 "non-technical" support workers at the hospital. Ms. Ramsay then estimated that because the average wage differential of the 17 jobs she examined was \$3.94 per hour, if the same differential were applied to the other non-technical workers (the workers in jobs that were not comparable to hotel workers), the hospital would save an additional \$2.8 million a year. The total annual savings for this hospital would be \$5.4 million a year, or 3.3 per cent of its total budget. From this she assumed that other hospitals would also have the opportunity to save about three to four per cent of their budgets by paying non-medical workers wages similar to those paid in hotels.

With these calculations Ms. Ramsay continued to extrapolate to give an idea of the savings that could be achieved if all of the HEU "non-technical" members throughout the province were paid hotel wage rates.<sup>6</sup> Using the assumption that the distribution of "semi-technical and non-technical" workers was the same in all hospitals, she estimated that about 74 per cent of the total HEU membership would fall into the group to be paid less. All together the province could save, according to these calculations, \$197.8 million a year, or 6.8 per cent of the total annual spending of acute care hospitals at the time.

**ASSESSMENT:** The Fraser Institute piece makes several heroic assumptions in its process of extrapolation that considerably exaggerate the wage differentials between hospital and hotel workers. (See Appendix I for wage comparisons between HEU, hotel workers and other workers in the public sector.)

### FAST FACTS

- Unlike hospitals, hotel food servers and housekeepers earn at least \$4 an hour in tips
- The "study" compares ticketed trades jobs with hotel maintenance positions
- Detailed job evaluations weren't conducted

<sup>5</sup> Interestingly, in the text of Ms. Ramsay's study, she refers to 18 job classifications, although her chart only includes 17. This is one indication of the sloppiness of this "study."

<sup>6</sup> She excludes technicians and others "who require specific medical knowledge to perform their duties" from the group of workers to receive lower wages.

The incorrect methods of the Fraser Institute study include the following:

- The Fraser Institute conflates full-time and part-time work, calculating all employees' wages as though they worked full-time. According to HEU essential service statistics on full-time equivalents in each job classification, there were 201 FTEs in the 17 job classifications at Royal Columbian Hospital, rather than 372 as used in the Ramsay calculations. In just this one calculation Ms. Ramsay overstates the wage differential by \$1.2 million, or almost half the savings she claims could be achieved at the outset at Royal Columbian by paying the workers the same as hotel workers in the 17 job categories.
- The Local 40 wage rates she uses are not indicative of the total income hotel workers receive for their work. In particular, food servers and housekeeping aides normally receive gratuities in addition to their basic wage.

An average of these gratuities cannot be precise, since they would vary by type of hotel and circumstances. Food servers in high-end hotels, for example, receive several hundred dollars a day in gratuities in addition to their wages. But for both food servers and housekeeping aides, gratuities in the amount of at least \$4 per hour would not be out of the ordinary.<sup>7</sup> This would make hotel and hospital compensation for this type of work about the same. The main difference is that hotel clients, rather than the employer, pays the gratuities.

- There are two significant problems with the information the Fraser Institute uses for comparing trades classifications. First, the HEU wage rates are for ticketed journey persons while the Local 40 comparisons are not for ticketed trades positions, but for maintenance workers. The qualifications of the two groups are quite different.

Second, according to Local 40 hotels, even large luxury hotels do not directly employ trades people. While hotels normally do directly employ maintenance workers, when qualified electricians, plumbers and painters are needed the hotels hire private contractors. In fact, the hotels would not be paying Local 40 rates for most of the work in this category, but would be paying standard union rates that are higher than those stipulated in the HEU contract (see Appendix I).

Since the greatest wage differentials in Ms. Ramsay's calculations are for work in the "trades" categories, the misrepresentation of how this type of work is performed in hotels creates considerable inaccuracies in the savings that could potentially be made. Her claim of a \$9.50 differential for electricians, \$8.67 for plumbers and \$8.46 for painters, produces a potential savings of \$390,000 a year for Royal Columbian Hospital just for reducing wages of trades people to hotel levels. The fact that hotels do not pay the wages she claims for this type of work makes this entire assertion false.

- As HEU has noted elsewhere, the province-wide savings calculated by the Fraser Institute study are based on an assumption that 74 per cent of the total HEU members are "non-technical" workers and could, therefore, have wage rates reduced an average of \$3.94 an hour (based on the average calculated wage differential in 1995).

<sup>7</sup> In fact, this is an extremely conservative estimate. Cleaners in high-end hotels can expect to earn between \$30 and \$60 a day in tips, in addition to their negotiated salary.

There are many problems with the kinds of extrapolation that arises from the failure to analyze the work requirements of the specific jobs in question. The most obvious problem is the assertion that a large proportion of HEU members are workers whose jobs do not require “specific medical knowledge.” HEU notes that a classification profile of its members in acute care shows that 45 per cent work in direct patient care, 17 per cent perform clerical work requiring medical knowledge and two per cent work in medical records. This means that only 34 per cent of HEU workers (rather than 74 per cent cited) would fall into the Fraser Institute’s so called “non-technical” classification.<sup>8</sup>

- There is also a problem with the methodology Ms. Ramsay uses to calculate the “average” hotel hourly wages. The Local 40 collective agreement stipulates wage rates for specific hotels and unless one knows how many people were working at each hotel in each occupational category, it would not be possible to construct an “average” wage rate in the hotel industry.

The figures that appear in the Fraser Institute paper seem to be constructed by simply adding the wages paid in each of the hotels and dividing them by the number of hotels, without reference to the size of the workforce in each hotel. This is an extremely rough and unreliable calculation of the “average wage” for each occupation in the hotel sector.

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- Finally it must be noted that the Fraser Institute claims relate to wage rates that are not comparable because they deal with different time periods. The Fraser Institute study uses hotel wage rates based on a 1991 agreement that had expired, and compares these with newly negotiated 1995 wage rates for HEU.<sup>9</sup>

In fact, the Fraser Institute study misrepresents the dates of the Local 40 collective agreement. The actual dates, according to the contract, were from Nov. 1, 1991 to Feb. 28, 1995, although the Fraser Institute claims it dated from Nov. 1, 1991 to Nov. 1, 1995.<sup>10</sup> There is a clear lack of correspondence in the dates used in comparing the wages across the two unions.

The method the Fraser Institute has used to calculate wage differentials between hotel workers and hospital support workers seriously exaggerates the difference between these two groups of workers. But the major problem with the Fraser Institute study is that it presents job comparisons in very blunt ways, ways that are not characteristic of how wage rates comparisons are usually done. That is, the Fraser Institute has not examined job classifications in hospitals and compared them with hotel workers’ jobs, but has merely assumed that they are the same.

Normally, job comparisons are undertaken by assessing four categories for comparison: the skills, effort, responsibilities and working conditions associated with specific positions. In this way people with different job titles but similar work can be compared and

<sup>8</sup> McIntyre and Mustel, HEU Membership Profile Survey, 2000.

<sup>9</sup> See *Collective Agreement between the Greater Vancouver Hotel Employers’ Associations and Hotel, Restaurant and Culinary Employees and Bartenders Union, Local 40*, 1 November 1991.

<sup>10</sup> Ramsay, 18.



their appropriate wages assessed. Also people with similar job titles can have very different responsibilities and working conditions that justify different wages in different work places.

Without an examination of the work actually being done within hospital and hotel settings, a comparison such as the Fraser Institute's cannot achieve reliable results. The following section examines the nature of support work in health care facilities compared to hotels. The evidence points to very substantial differences in the nature of support work in hotels and hospitals, and provides a basis for understanding why wage rates are higher in health care facilities than in hotels.

### III. Examining support work in hospitals

**T**HE INFORMATION FOR THIS SECTION relies heavily on interviews undertaken at a variety of hospitals and long-term care facilities with health care support workers, nurses, doctors and other hospital personnel. (See Appendix II for information about the methodology of this paper.) While there is an extensive literature on the working conditions, skill levels, and responsibilities of the medical and technical staff in hospitals, nothing comparable exists for other hospital personnel.

The few references to food servers, laundry and clerical workers in the recent literature focus on either health and safety issues or contracting out, and make little reference to the specific conditions faced by support workers in health care sector.<sup>11</sup> The work of hospital-based trades persons has not been examined at all.

There are, at the same time, a small number of significant studies on the work of cleaning staff in hospitals in Montreal.<sup>12</sup> These studies raise many specific issues that will be discussed in subsequent sections. In general the findings from these studies point to the fact support services in hospitals are crucial to the correct functioning of a hospital and that too often support workers' skills are undervalued because their work is not visible or acknowledged by the professional and administrative staff.

#### FAST FACTS

- **Marjorie Cohen conducted detailed interviews with support workers and other health care professionals**
- **There's limited academic literature on the role of support workers**
- **But one key study says support workers' skills are undervalued**

<sup>11</sup> See Wayne Jensen, "Contracting Out Building Cleaning Services at the National Hospital Of Denmark," *Contracting out Government Services: Best Practice Guidelines and Case Studies*, no. 20 (1997): 27-30; David J. Gawkrödger, Margaret H. Lloyd, and John A.A. Hunter, "Occupational Skin Disease in Hospital Cleaning and Kitchen Workers," *Contact Dermatitis* 15 (1986):132-135; M.A. Borg and A. Portelli, "Hospital Laundry Workers – An At-Risk Group For Hepatitis A?" *Occupational Medicine* 49, no. 7, (Sept. 1999): 448-50.

<sup>12</sup> See Karen Messing, "Hospital Trash: Cleaners Speak of Their Role in Disease Prevention," *Medical Anthropology Quarterly* 12, no. 2, (June 1998): 168-187; Karen Messing, Celine Chatigny, and Julie Courville, "'Light' and 'Heavy' Work in the Housekeeping Service of a Hospital," *Applied Ergonomics* 29(6), 1998, 451-459; Daniel Tierney, Patrizia Romito, and Karen Messing, "She Ate Not the Bread of Idleness: Exhaustion Is Related to Domestic and Salaried Working Conditions Among 539 Quebec Hospital Workers," *Women & Health* 16, no. 1 (1990): 21-41.

The following examination of the distinct skills, responsibilities and working conditions of housekeeping staff, laundry workers, trades persons, food and clerical workers will show that the work of support staff in health care is considerably more complex than is normally understood, and constitutes work that is substantially different from that undertaken within hotels.

An examination of support work in health care shows how important this work is to the efficient running of hospitals and, in most cases, to the health of patients. The distinction between “caring” work and the work of the support staff is not as clear-cut as is often assumed; the work of the “non-technical” support staff is directly related to patient care. In addition, and particularly noteworthy, is the fact that all health care support occupations require considerable health care specific knowledge, skills and on-the-job experience and training.

**HOUSEKEEPING/CLEANING:** The work of housekeeping and cleaning staff in health care facilities cannot be easily compared to the work performed by housekeeping staff in hotels. It differs in a number of respects including the standards of cleanliness required, the complexity and technical sophistication of the physical environment and health hazard risks for housekeeping/cleaning staff. In addition, the contact with patients makes the work of housekeepers in hospitals quite distinct from housekeepers in hotels.

#### **RESPONSIBILITIES, SKILLS, AND TRAINING**

Cleaners/housekeepers in health care facilities follow stringent and detailed cleaning procedures that vary depending on the type of facility and the specific area in which they work. Hospitals prefer to hire people who have completed the Vancouver Community College Institutional Aid Program.<sup>13</sup> The three-month cleaner program (five months for ESL students) deals with all aspects of cleaning, with particular emphasis on health care cleaning, sanitizing and chemical use. Cleaners also receive additional on-the-job training in emergency codes related to incidences of patient violence, evacuation procedures, and fires.

Different hospital units, such as the operating room and other areas where patients are particularly vulnerable, require special cleaning techniques and additional training. This training is usually provided by a nurse or other qualified health care professions. What follows is a description of the specialized nature of cleaning in specific hospital units.

#### **Operating Rooms:**

Operating rooms require the highest standards of cleanliness and must be left sterile and immaculate. According to one worker, “cleaning minute drops of blood requires a mind set not obvious to anyone who is not trained to clean this area.”

The housekeeping staff work around sensitive and expensive equipment and yet need to be fast and efficient. In some cases there is only a 15 minute turn-around time between patients, and cleaning staff are frequently working while doctors and nursing staff are getting organized and bringing in equipment for the next patient. No time allowances are

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<sup>13</sup> See the Vancouver Community College *Building Service Worker Program Outline* for a detailed description of the cleaning program.

made for the type of surgery performed, something that puts added pressure on the cleaners since some types of surgery require a great deal more cleaning than others. Blood, bones, bone chips, teeth, tissue and fat fall on the floor and make cleanup dangerous and unpleasant.

**Dialysis Units:**

Patient turnover rates in dialysis units are very high. There are serious sanitation issues to consider in this unit because it is a place where the risk of cross-infection is high. The time pressures create stressful work situations for the cleaners – one worker at Vancouver General Hospital says she changes 22 beds in an hour. As soon as a patient leaves, the sheet and pillowcase are replaced, all spills cleaned up and linen bags removed.

**Emergency Departments:**

These departments experience very high turnover rates that create considerable stress for cleaners because the cleaning demands are heavy. Stretchers that are often covered with blood, vomit or other bodily fluids are difficult to clean quickly and must be washed between each patient. VGH Emergency has a “quiet room” for violent patients that is often soiled by feces, urine, blood and vomit that cleaners must deal with regularly.

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**‘Intensive cleaning in burn units is required because the risk of infection is high’**

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**Radiation Rooms:**

Cleaning radiation rooms requires protective clothing and special cleaning with cleansers like Isoclean. A special protocol exists for using this material. The process is very time-consuming and yet the additional time required is not factored into the cleaner’s schedule. After the cleaning is finished, the room is monitored for radiation. If any “hot spots” are found, the room must be cleaned again.

**Burn Units:**

Intensive cleaning is required in burn units because the risk of infection to patients is particularly high. Everything in the room, including blinds, wall and all surfaces are carefully cleaned more regularly than in most other units.

**Infection Control – Antibiotic Resistant Organisms (ARO):**

The increasing prevalence of organisms that are resistant to antibiotics, such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE), is a serious problem that has direct consequences for cleaning standards at health care facilities. As a result of the difficulty of treating these diseases, hospitals focus on preventing the spread of organisms through specific cleaning protocols. MRSA, for example, can live outside the body for a lengthy period of time, so it is relatively easy to pass it from one patient to another, unless special precautions are taken. In this sense, controlling AROs is primarily a housekeeping issue.

Special protocols exist for cleaning rooms of MRSA and VRE patients. Everything in the room, including the bed, wall, floor, furniture and privacy curtains around the patient’s

bed, are cleaned with the disinfectant Phenokill and bleach. Cleaning staff are conscious of and trained to deal with the threats to patients through the spread of ARO organisms and of the need for special precautions when cleaning.

In summary, hospital housekeeping staff must have specialized knowledge specific to a health care site and unit where they work, and are required to follow complex and exacting cleaning protocols. They are very conscious of the risks involved in their work and of the very serious consequences of making an error.

### **PATIENT CONTACT**

Housekeepers are well aware of the significant role they play in the well-being and recovery of patients and residents. According to one worker at VGH, “We are the frontline against infection. We are the ones who make the hospital safe.”

While housekeeping staff are not directly responsible for patient care, they see patients for a minimum of 20 minutes a day. Their presence in the room often gives people who are lonely – particularly out-of-town patients – needed support. They also play an important role in handing patients blankets and out-of-reach items, opening drink containers, getting personal items, notifying a nurse of problems and conversing with patients.

Sometimes patients have legitimate needs that have not been addressed, making the observation of the housekeeper particularly important to the patient’s well-being. One housekeeper described working in a room where the patient sat shivering, without slippers and little clothing on. He gave the patient a blanket and felt appreciated because “she smiled.”

Since interactions with patients are not a direct responsibility of the housekeeping staff, the time workers spend doing this type of work is “stolen” from their normal jobs and time becomes a difficult issue. However, some of the housekeepers, particularly from long-term care facilities, report that their administrators do recognize the value of the time they spend with residents and have incorporated this into the workload.

In addition some of the newer models of care, in both long-term and acute care, combine the job requirements for housekeepers and care aides. The idea is to provide more stable and familial care to the patient/resident by assigning staff to work with fewer residents but requiring them to do a broader range of activities with those patients/residents (i.e., both care and housekeeping).

Housekeeping staff frequently become close to patients/residents and their families and, as a result, experience a great deal of emotional stress through their job. They see pain, fear and suffering and are affected by the trauma of the patient and their families.

In particular, staff mentioned the emotionally draining nature of working with people who have been abandoned by their families and friends, young people who are critically ill, all the patients/residents who die, sometimes while the cleaners are in the room, and the trauma of finding suicide victims. One cleaner in a long-term care facility described the pain of cleaning out “the personal possessions of someone who has died – it is like wiping away the patient’s life.”

All of these interactions with patients make the work of hospital cleaners – even in the normal routine of cleaning patients’ rooms – quite different from the work of a cleaner in a hotel. The cleaning is more demanding and complicated because patients are often present and require additional support and assistance.

## **HEALTH HAZARDS**

Health care workers are recognized to have particularly higher exposure rates to health and safety risks on the job than the general work force. According to the Workers’ Compensation Board, cleaners/housekeepers in hospitals and long-term care facilities have injury rates that are more than four times that of the average industrial worker.<sup>14</sup>

The occupational hazards associated with housekeeping staff can be grouped into four categories. These are:

- biological and infectious hazards;
- chemical hazards;
- environmental and mechanical hazards; and
- workload hazards.<sup>15</sup>

These occupational hazards are specific to health care and not hotel housekeeping work. In themselves they would justify a substantial wage difference between hospital and hotel housekeeping staff.

## **FAST FACTS**

- **Cleaners follow stringent procedures. They are the frontline against infection**
- **Housekeepers see patients at least 20 minutes a day**
- **They face a range of biological and workload hazards, and sky high injury rates**

### **Biologic and Infectious Hazards:**

Cleaners in health care facilities are constantly exposed to infectious substances. Some of the risks are built into the job, simply through contact with patients or bodily fluids. Other biologic and infectious risks arise from the improper disposal of needles.

One worker who was interviewed has had 13 needle sticks. These needle sticks are extremely dangerous because they expose health care workers to blood-borne pathogens such as HIV, Hepatitis B virus (HBV) and Hepatitis C virus (HCV).<sup>16</sup> A major study of occupationally-acquired infections in health care workers found that there is a bigger risk for Hepatitis B among cleaning service employees than among nurses.<sup>17</sup>

According to a medical microbiologist at an acute care hospital who was interviewed for this study, the biggest health risks for hospital cleaners come from contact with TB, chickenpox, respiratory tract illness, and blood borne pathogens. It is also worth noting that the recent resurgence of tuberculosis has profoundly altered views about the risk of tuberculosis in health care workers, particularly since the emergence of multi drug-resistant strains of TB.<sup>18</sup>

<sup>14</sup> Health care cleaners’ injury rate is 17 per cent compared with a 4.1 per cent injury rate for workers in all industries. (Worker’s Compensation Board Statistical Services, special run for the Hospital Employees’ Union, 1999).

<sup>15</sup> *Ibid.*, 249.

<sup>16</sup> Denise Cardo and David Bell, “Bloodborne Pathogen Transmission in Health Care Workers,” *Infectious Disease Clinics of North America* 11, no. 2 (June 1997): 331-346.

<sup>17</sup> Kent A. Sepkowitz, “Occupationally Acquired Infections in Health Care Workers, Part II,” *Annals of Internal Medicine* 125, no. 11 (1996): 918.

**Chemical Hazards:**

Chemical exposure can occur through inhalation, ingestion and absorption through the skin or mucous membranes. Common hazards include exposures to disinfecting or sterilizing agents such as glutaraldehyde and ethylene oxide, chemotherapeutic agents, waste anesthetic gases and latex.<sup>19</sup>

Housekeeping staff are in constant contact with chemicals. Some chemicals are particularly dangerous if they are airborne and staff need to know under what conditions they can and cannot be used. The housekeeping staff interviewed for this study indicated adverse reactions to various types of chemicals including skin dermatitis and allergic reactions to cleaning agents such as Phenokill.<sup>20</sup>

In addition to chemical exposure, housekeeping staff also have to deal with hazards of physical agents in the environment such as exposure to body fluids from patients receiving metabolized therapeutic nuclear radiation. In some hospitals cleaning staff have also taken over responsibility from nurses of cleaning up mercury spills.

**Environmental and Mechanical Hazards:**

Housekeeping staff have very high on-the-job injury rates. Lower back, shoulder and neck injuries are most common.<sup>21</sup> The housekeeping staff specifically mentioned problems with the weight and contents of linen bags. This is a problem especially in the Lithotripter area (treatment for kidney stones) where linens and towels are soaking wet. Also frequently mentioned are problems that arise with electric and operating room beds that are difficult to clean because of their many moving parts. The weight of these beds (up to 1,000 kilos) makes them very heavy to move when cleaning the floor, even though they are on casters.

**Workload Hazards:**

The workload in health care facilities has intensified over the 1990s for a variety of reasons, including greater patient acuity, early discharges and higher patient turnover. Without increases in housekeeping staff, this has made it difficult to complete work on schedule, or to at least do it well and on time.

This creates great stress among the staff because they are acutely conscious of the high standard of cleanliness that is essential in the hospital and that is expected of them. High workloads are exacerbated by the increased cleaning needed for MRSA or VRE patient rooms, but no additional time has been allocated for the work. A worker at St. Vincent's

<sup>18</sup> Dick Menzies, Anne Fanning, Lillian Yuan, and Mark Fitzgerald, "Tuberculosis Among Health Care Workers," *New England Journal of Medicine* 332 no. 2 (Jan. 12, 1995): 92-98; J. Louthier, P. Rivera, J. Feldman, N. Villa, J. DeHovitz, and Kent A. Sepkowitz, "Risk of Tuberculin Conversion According to Occupation Among Health Care Workers at a New York City Hospital," *American Journal of Respiratory Critical Care Medicine* 156, no. 1 (July 1997): 201-5.

<sup>19</sup> Bonnie Rogers, "Health Hazards in Nursing and Health Care: An Overview," *American Journal of Infection Control* 25 (1997): 252.

<sup>20</sup> See Gawkrödger et al, 132-135.

<sup>21</sup> According to the Workers' Compensation Board, workers in acute care hospitals in 1999 had an injury rate more than 70 per cent higher than that of the average worker in all industries. Those in long-term care facilities have injury rates almost two and a half times greater than the average worker (WCB Statistical Services, special run, 1999).

Hospital in Vancouver talked about the increase in workload as a result of increased eye surgery – on days when there are extra surgeries her workload doubles.

Restructuring in many health care facilities also has increased the workload because of staff cutbacks or the elimination of positions for orderlies, escorts, transport staff and licensed practical nurses. These cutbacks have consequences for housekeeping staff because they usually have to pick up some of the work. In addition to the extra work, restructuring also negatively effects the stress level of professionals and patients and this stress seems to become, as one worker said, “infectious.”

In addition to problems with workload is the stress and physical injury caused by the high rate of physical aggression and violence against workers in health care. The violence housekeeping staff encounter can come from patients or family members who misdirect their anger at staff. The emergency room is an especially dangerous area, as are long-term care facilities and special units in the hospital where dementia patients are cared for.

**HOTEL CLEANERS:** The range of hazards health care workers encounter are simply not comparable to work hazards in hotels. An interview with a representative of Local 40 revealed that there are health and safety issues for hotel workers, but these are not as serious as they are for workers in health care facilities. Room attendants (those who clean the rooms) tend to get back injuries and injuries associated with repetitive motion, but they are not routinely exposed to the hazards from patients or from dangerous substances. Also, since they have little contact with hotel guests, they experience few incidents of harassment and virtually no incidents of violence.

#### **CLEANING STANDARDS IN HOTELS**

Cleaning standards in hotels are radically different from those in health care facilities, and this in itself makes the nature of hospital cleaning substantially different. While no systematic studies of hotel cleanliness have taken place in Canada, there is information about brand name hotels in the U.S., many of which have establishments in Canada. Scientists at the University of Arizona have studied and published on this issue and, as a result, lack of hotel cleanliness has gained considerable attention.<sup>22</sup> Dr. Charles Gerba, a microbiologist and the primary author of the University of Arizona study, examined the cleanliness of hotels in the U.S. for the ABC News program, *Prime Time Live*.<sup>23</sup>

The study analyzed hotel and motel rooms throughout the U.S., testing respected name brand places and luxury hotels for coliform bacteria and E coli.<sup>24</sup> All the bedding showed a presence of urine or semen and these substances were also present on carpets, upholstered furniture and on the walls. Semen stains were even found in a \$700 a night suite. Fecal bacteria were found in bathrooms, but also in peculiar places such as on the telephone and the TV remote control. The assumption was that the same cloth was used for cleaning the bathroom as was used for the rest of the room.

<sup>22</sup> Charles P. Gerba, Moyasar T. Yahya, Timothy M. Straub, and Jenna M. Cassells, *Microbiology of Hotel Bathrooms*, (Tucson: University of Arizona, Department of Soil, Water and Environmental Science, 1990).

<sup>23</sup> Gina Pampinella and Sylvia Chase, “Clean Sweep,” *Prime Time Live*, ABC News, 11 March 1998.

<sup>24</sup> The presence of coliform bacteria indicates presence of filth. E. Coli indicates the presence of fecal matter. The average price for the rooms examined was \$160 U.S. a night.

Dr. Gerba noted that disinfectants were not used when cleaning. He pointed out that bacteria pseudomonas present in these rooms may not be very dangerous to healthy people, but are a telltale sign of a dirty room and it was found everywhere at high levels – even in ice machines and coffee pots.<sup>25</sup>

The main conclusion to draw from the U.S. study is that hotel cleanliness is of a different order from that essential in a hospital. People may be disgusted from contact with semen, urine and fecal material they encounter in hotels, but, if they are healthy, they probably will not get very sick. However these kinds of conditions cannot be replicated in a hospital because they are breeding grounds for organisms that could be lethal for someone who is ill.

**LAUNDRY WORKERS:** Laundry work associated with health care facilities carries responsibilities and risks that differ substantially from hotel laundry work. The laundry requirements of specific hospital units are unique and require specialized knowledge and skill acquired by workers through experience and training on-the-job. Similarly, the distinct substances encountered in a hospital laundry relate to bodily fluids and contact with them makes this type of work especially hazardous.

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**‘Special skills are needed for the requirements of OR laundry’**

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Much of the employee information for this section comes from laundry workers at the Tilbury Regional Hospital Laundry in Delta. This laundry is a publicly owned facility that processes about 28,000 kilograms of hospital linens every day for many Lower Mainland health care facilities. In general the workers describe Tilbury as a state-of-the art laundry that is well managed, efficient and highly mechanized.

#### **RESPONSIBILITIES AND SKILL**

Laundry workers require distinct skill to deal with the special laundry needs of different hospitals and specific units within health care facilities. For example, isolation laundry is washed in separate manually loaded machines. Workers must be especially conscious of heavily stained items that require treatment with appropriate chemicals and must be washed often and then rewashed. Different fabrics cannot always be mixed because of the different heat and chemicals used in the cleaning process.

Special training and skill are needed for the requirements of operating room laundry. Surgical gowns and other operating room supplies are laundered separately because they are made from microfibre, a specialized fluid-resistant material. Operating room linens (gowns, sheets, coverings, pants), in particular, require higher levels of cleanliness and scrutiny than laundry associated with most other units.

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<sup>25</sup> The problem of poor hygiene in hotel rooms has spawned a new product that allows hotel guests to gage the cleanliness of their rooms. It is a Rest Assured Personal Inspection Light – a 4.8-watt, battery operated ultraviolet tool designed to expose dried bodily fluids. (Jane Costello, "This gismo could just bring out a little compulsiveness in us all," *The Wall Street Journal*, 13 October 1998, Interactive Edition, B1); Hanna Rosin, "What Work: Germ Warfare," *The Washington Post*, 9 May 1999, Final Edition, WO6.



A special operating room floor is designed to deal with clean surgical linens. On this floor laundry is separated into categories and checked very carefully for lint and any loose fibers. This is an essential task to ensure that patients are not infected by stray particles during surgery. Each microfibre gown and sheet or drape is inspected on a light-table for holes, tears and other defects and is either repaired or recycled.

Folding operating room linens into surgical bundles is a skill that requires specialized training to meet the Canadian Standards Association's (CSA) International standard. Microfibre surgical gowns require special attention to ensure that the gown remains sterile when taken out of the bundle prior to surgery. According to one worker, "The gown is worn after doctors have scrubbed for surgery so the exterior of the gown must not come in contact with anything. If things are not folded correctly, the gown is discarded and the doctor takes a new one." Similar care is taken in the special folding of surgical sheets.

Particular skill and diligence are also necessary when assembling surgical bundles for different operating rooms. There are 21 types of surgical bundles assembled for St. Paul's Hospital alone. For example, a standard bundle for transfusion includes a huck towel, an OR gown and six single towels wrapped in a microfibre sheet.<sup>26</sup> A burn unit bundle includes four pillowcases, one fitted sheet, one flannelette sheet, one bed sheet, four bath towels, one cellular blanket, and one microfibre wrapper.

According to one laundry worker with 20 years experience, "It takes weeks to learn the job and maintain continuity, but it takes months to learn to do the job efficiently."

The importance of an efficient laundry service to the effective work of a hospital cannot be over estimated. A supervisor at one hospital which had contracted out its laundry to a private, commercial laundry, explained some of the problems with the privatized service, "When aprons were sent out, they would come back so tangled up that it would take hours to sort out – they had to be thrown out. Rags and uniforms sent out would never come back, or if they did they were tangled up with underwear, socks and pads that didn't belong to anyone in the facility. Uniforms would be washed with heavily soiled items, and come back unwearable. Staff would have to take their uniforms home to be washed."

Ultimately the problems this hospital experienced were so serious that the laundry work was brought back in the hospital itself.

### **HEALTH HAZARDS**

Because of the nature of the linens being washed, the workers at Tilbury are exposed to hazardous and infectious substances. In fact, hospital laundry workers are among the most susceptible of all health care workers to an array of specific infections.<sup>27</sup> They are particularly susceptible to salmonellosis and scabies.<sup>28</sup> Since these workers have no direct contact with infected patients, the contamination is almost always transmitted through contaminated linen.<sup>29</sup>

<sup>26</sup> A "huck towel" is a small terry towelette.

<sup>27</sup> Sepkowitz, 922. Included among those most at risk for infection are laboratory personnel, veterinarians and animal handlers, pathologists, surgeons, dentists, anesthesiologists and laundry workers.

<sup>28</sup> Lice, scabies, and crabs are common. At Tilbury an exterminator disinfects the area around the washers once a week.

<sup>29</sup> Sepkowitz, 920.

A British study found that laundry workers who consistently handled dirty linen had higher odds of contracting Hepatitis A than colleagues who handled only clean items. They concluded that the “increased exposure of hospital laundry workers to potentially infected linen can constitute a risk of occupational Hepatitis A.”<sup>30</sup>

At Tilbury all 28,000 kilograms of laundry, which often is soaking wet, must be sorted by hand each day. The workers who do this “first assault,” or “soil sort” must individually handle each item and sort it according to whether it belongs in various bins designed for regular (automated) laundering or if they should be put in the red bio hazard sling bags for isolation (manually loaded) laundering. The laundry bags weigh 5.5 kilos empty and more than 90 kilos when full.

The workers in the soil sort and the isolation laundry are in the most hazardous work areas. Generally, in the hospital bio-hazardous material is kept separate from other garbage and other items, (i.e., diapers) which are supposed to be cleaned prior to disposal. But often these items end up in linen bags and are left to the laundry to sort.

During the sort workers find surgical instruments, such as scalpels and blades, IV sharps, and syringes. According to one of the workers, “Needle sticks are surprisingly uncommon because everyone is trained to watch for these kinds of things. But every day you worry and talk about the dangers of needles.” Clearly the significance of training and experience on the job is crucial to keeping the injury rates down.

They also find colostomy bags, soiled dressings, and body parts, including umbilical cords and internal tissue. One worker found a placenta wrapped in a bag. All of these are potentially dangerous to workers. Microfibre linens associated with surgical procedures present a particular problem because the fabric is fluid resistant. These microfibre items are sometimes full of bodily fluids or coagulated blood. One worker said one of these items “can resemble a body part but is just a big clump of blood.”

In concluding this section it is worth noting that the health care specific knowledge, extensive on-the-job training requirement and risk hazards in hospital laundry work makes simplistic comparisons with hotel laundry work (as the Fraser Institute proposes) quite difficult to make.

**THE TRADES:** The work of trades persons in hospitals is distinct from work in hotels in crucial ways. These differences relate to:

- the need to have specialized knowledge of medical equipment and frequently changing and complex technologies;
- the importance of specific on-the-job experience and knowledge of hospital systems, structures and processes and the implications for patient care and safety;
- the need to frequently work in and around patients and with other professionals in the hospital; and
- the need to know how to handle hazardous materials and substances.

<sup>30</sup> M. A. Borg, et al, op cit, 448-50.

As noted earlier in the assessment of the Fraser Institute report, hotel maintenance work is not comparable to the work of the certified trades personnel in a hospital in terms of years of training and apprenticeship requirements. The higher levels of trade certification necessary in hospitals are clearly a result of the higher demands of the work.

### **RESPONSIBILITIES AND TECHNICAL KNOWLEDGE**

Trades people who work in health care facilities need to deal with issues relating to air quality, heating, water, and medical gases. There is a much greater responsibility regarding these issues in a hospital than in a hotel because of a hospital's structural complexity, and the numerous safety and quality control concerns. As an electrician explained, the main difference between work in a hospital and work elsewhere is the need to intensely concentrate on the ramifications of each action. An electrician needs a thorough knowledge of the distribution system and to be aware of how these systems connect to each other. If a whole section shuts off, the electrician has to go through the drawings to know who and what will be affected.

This knowledge is learned in-house; it is only from experience on-the-job that the electrician acquires this information. As one electrician noted, it took him five and a half years to learn the layout of the entire hospital where he works.

Similarly, a critical area for plumbing involves maintaining the quality of the drinking water. Drinking water is vulnerable to back-flow from contaminants such as radiation from the x-ray department. Some plumbers felt that there should be random, periodic testing of water quality and mandatory testing of cross-connection back-flow valves, a quality control that is not now carried out in all hospitals.

Another example of the specialized nature of work in a hospital is the need to ensure that acid fumes do not contaminate medical lines for medical air treatment. Separate filters need to be in place to ensure that medical air treatment is safe and unpolluted. In general, trades workers in hospitals need to be – and are – extraordinarily safety conscious, not simply because of the implications for themselves, but for the safety of patients in the hospital.

Because of the technical difficulty of hospital systems and equipment, the knowledge required for the job is greater than is necessary for work in hotels. A particular difficulty is that trade workers in hospitals are constantly dealing with other professional staff and with systems and technical equipment that change rapidly. The general requirement for trade workers in hospitals is a Grade B Journeyman, although most have an A ticket and most tend to be multi-skilled. For example plumbers usually also have gas fitters and cross connection trade qualifications and medical gas trade qualifications are becoming a job requirement.

### **FAST FACTS**

- **It took one electrician five years to learn the hospital's entire layout**
- **Hospital trades people frequently "gown-up" to work around patients**
- **Contact with dangerous substances and bodily fluids is a regular part of the job**

## **PATIENT CONTACT**

A major distinction between hotel workers and those in a hospital is that hotel workers rarely need to go into a room when “guests” are in them. Hospital workers often have to deal with patients being in a room, and sometimes even in a bed they are working on. This was the situation described by a machinist who needed to repair an occupied bed in the intensive care unit. It requires special skill – skills that are learned on the job and come with experience in communicating with other professionals and patients in a health care setting. As one worker noted, “Working in patient areas where there are antibiotic resistant organisms, or in renal areas, requires an acceptable level of decorum that is very different from working on a construction site.”

In some circumstances the trades person needs to take precautions to ensure that the surroundings remain sterile. This means being conscious of where tools are placed and, in some cases, of taking universal precautions and needing to “gown-up” to ensure infection is not spread from one area of the hospital to another.

Trades people find working on live systems that people are connected to stressful and very demanding. This is particularly so when working in the OR during an operation or on back-up systems while a doctor is taking care of patients. They feel that the competency this requires is not normally recognized within the hospital.

Generally, the work of trades persons is thought of as quite distinct from the “caring” professions because it is assumed that these workers perform their tasks behind the scenes and away from patients. It is, therefore, surprising to hear trades people talk about their work largely in terms of what it means for patients.

For example, an electrical foreman at an acute care hospital described a very simple part of the electrician’s job that he felt was critical for patient safety and comfort, “Some of the most trivial jobs, and the most frequent are hugely important to patients.” He gave as an example the problem of replacing and repairing cheaply designed three-way over-head lights on beds. The switches controlling the night light, room light, and reading light are constantly breaking. To repair them the electrician needs to negotiate around the patients, which often means negotiating around tubes and drips.

## **HEALTH HAZARDS**

Hospital trades people routinely deal with dangerous substances, and contact with bodily fluids and body parts are all part of the job. Plumbers need to be particularly aware of the contents of drains and traps because dangerous substances like mercury and chemicals to sterilize equipment may be poured down them. The medical vacuum system often gets backed up with contaminants, a situation that is dangerous when it is being repaired.

When plumbers repair or remove toilets, they come into contact with bodily fluids, including irradiated bodily wastes from patients receiving radiation therapy. When plumbers come in contact with cytotoxins they must gown-up, wear disposable overalls, and wear face shields to do the work. One plumber pointed out that B.C. Ferries pays an extra \$8 per hour for work done on gray water (sewage), but hospital plumbers are not similarly compensated for their exposure to contaminated sewage.

Plumbers also often come into contact with sharps that have been improperly disposed of in the sink. Almost any aspect of plumbing repair in the hospital is more dangerous than work in a hotel. This is recognized by the special protocols that exist to control the handling of designated substances, precautions that are outlined under provincial Workers' Compensation Board regulations. Hotel workers do not have to deal with controlled substances.

Exposure to contaminants also occurs through contact with exhaust systems, a concern that was raised by HEU members on one hospital's health and safety committee. And machinists indicate a need to know the kinds of contaminants they are breathing when working on exhaust fans that vent laboratories and other areas with airborne substances.

From these examples it is clear that trades workers in hospitals are exposed to dangerous conditions that are ill-defined and that are radically different from the conditions found on other worksites. Although hotel workers do encounter bodily wastes and the occasional syringe, they are not routinely exposed to such bio hazardous substances and infectious agents.

**CLERICAL WORKERS:**<sup>31</sup> Clerical work in health care is substantially different from clerical work in a hotel. Even work that may seem directly comparable because job titles are similar like switchboard operator, admitting, stores, and purchasing clerks (the four positions compared with hotel workers by the Fraser Institute) – in fact has substantially different levels of responsibility. One main difference relates to the health care specific knowledge and responsibilities required of clerical workers in hospitals and long-term care facilities.

Clerical staff are expected to have the on-the-job experience and training to deal with patients and other health care professionals under intense stress. At the same time they must be able to focus on the technical accuracy and details that are critical in admitting/discharging patients, creating and maintaining medical records and/or purchasing supplies.

#### **RECEPTIONIST**

A clerical worker who works as a receptionist in an acute care hospital deals directly with communications issues in the hospital and is the main source of contact between the public and the hospital. It is a position that requires considerable health specific knowledge and has responsibilities that are quite different from hotel reception work.

A hospital receptionist must respond to telephone inquiries when callers want specific information about patients, and when reporters call about accident victims or other newsworthy patients. Special skills are required to deal with aggressive reporters, or rude and anxious or unhappy people. When dealing with issues about highly public people and sensitive political issues, the job can be very demanding. In all cases the issue of patient confidentiality and safety is paramount.

The receptionist also maintains lists of patient contacts and guardians for patients who are unable to speak for themselves. Knowledge of how the hospital works is a primary require-

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<sup>31</sup> The term "clerical" is a misnomer: It includes virtually all positions that are distinct from those in housekeeping, trades, food, and laundry. It includes admitting, switchboard, stores, and purchasing.

ment. Since there are often no written procedures, the receptionist's familiarity with the staff and hospital procedures is crucial.

Receptionists often have duties that extend beyond contact with the public. One receptionist reported duties such as releasing news reports, booking meeting rooms, answering requests for hospital publications, maintaining a newspaper clippings file, and taking responsibility for communications from the president's office, including opening mail and sending and receiving confidential faxes.

### **ADMITTING CLERKS**

As with the receptionist, an admitting clerk requires considerable health care specific knowledge and has responsibilities that are substantially different from hotel reservation clerks. In particular, the contact with patients and interaction with hospital units demands medical knowledge that is specific to this job. The following is a snapshot of some aspects of an admitting clerk's work in an acute care hospital.

Work in admissions is carried out through pre-admitting, main admitting, emergency admitting and terminal case registry for discharged persons. Admitting clerks deal with everything from collecting patient information to booking patients into the operating room or maintaining patient records after discharge. Often it is very challenging to obtain personal information from patients, particularly when they are very ill or upset, or are uncomfortable with giving out this type of information. Emergency room work is particularly difficult since it often requires interviewing distressed relatives and patients at the bed side as they await medical attention.

In addition, the responsibilities associated with accurate data collection are considerable since this data may be vital to a patient's treatment plan. For example a duplication error on a medical record could cause the wrong laboratory results to be attached to a patient's chart.

In general the job requires tact, patience, experience, and flexibility. Shortages of hospital personnel, like nurses, have put enormous stresses on the admitting staff. According to one person working in admitting, "It makes it difficult to assign beds because either beds are not available or it is difficult to get information from the nurses. If there is a nursing shortage, beds close."

### **STORES**

The range and complexity of supplies in a hospital are quite different from a hotel. The capital equipment is more complex, the number of items that need tracking is much greater, and the consequences of errors are potentially lethal.

In a large acute care hospital a large number of people work in stores. At VGH, for example, 100 people deal with the shipping and receiving of approximately 10,000 different items – clearly an inventory that far exceeds anything in a hotel or bar. Stores receive all supplies delivered to the hospital except blood products and pharmaceuticals. They deal

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**'It's challenging to obtain patient data when they are very ill or upset'**

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with supplies for patient units, maintenance, security, offices, trades, cleaners, and kitchens. With regionalization, stores departments are increasingly being centralized, and they now must deal with the complexities of supplying multiple sites.

The knowledge of stores personnel is crucial to the department's correct functioning. All hospital stock is coordinated through the stores department, from hip replacements to breast implants and heart pacemakers. Workers in stores need to know what the products are, and what to look for when requisitions are received. So, for example, when blood coils are needed for transfusions, the stores technician needs to know not only the product's name, but also the generic terms used, the stock number, and the catalogue name.

Sometimes there is only a digit difference in product codes – this is something that the stores person needs to know. For example, Phenokill concentrate that is used for room cleaning is different from Phenokill for equipment cleaning, and the workers in stores are required to understand the difference. This knowledge comes through years of experience in a health care setting. For example, if a dialysis unit requires a saline IV solution and glucose was sent instead, there could be serious consequences for the patient.

Also there are times when the pressure of the job is acute – particularly when there has been an accident and a large number of patients are anticipated at short notice. According to one worker, “stores may have only eight minutes to respond.” The quick responses are crucial. But, at the same time care needs to be taken to ensure that the seals on sterile equipment have not been broken and expiry dates of items like pacemakers have not passed.

Even though they do not have direct contact with patients, stores workers are acutely conscious of the responsibility of providing life saving supplies for patient care. As one worker noted, “even if it is only one patient using a particular item, stock can be depleted.” And, depleted stock can have very serious consequence.

## **PURCHASING**

Purchasing itself is extremely complicated and requires formal skills that are acquired both through professional training through courses and on-the-job training. Purchasers need to deal with both the professionals within the facility and the private sector salespeople who bid on hospital purchases. Purchasing staff are expected to have a thorough knowledge and understanding of the products available on the market and to keep up-to-date on improvements in technology that occur very rapidly with medical items like wheelchairs.

In addition, unwarranted delays can arise because of multiple funding sources for equipment purchases and complex approval processes. As a result, purchasing staff must also be tenacious advocates to be effective in their work. They often take on the responsibility of sorting through bureaucratic processes and roadblocks. As one purchaser noted, “if you just follow your job description, then there are many things that wouldn't get done.”

Ultimately the purchaser has to deal with units and people who are frustrated when what they need is not available. According to one purchaser, the “stress of working in the hospital arises from having to talk to frustrated hospital managers who are waiting for their requests to materialize.”

In summary, each of the clerical jobs described above – receptionist, admitting clerk, stores clerk and purchasing clerk – requires considerable specialized health care knowledge, training and expertise and has responsibilities that quite distinct from hotel clerical work.

### **FOOD SERVICE WORKERS (FSW) / FOOD SERVICE SUPERVISORS:**

The major difference between food service work in a health care facility and a hotel is that in a hospital workers are dealing with dietary needs of sick people – needs that require experience in a health care setting, special awareness and knowledge of government regulations and training in the appropriate preparation, monitoring and reporting protocols. Food service work is mentally challenging, fast paced, and integral to the comfort and safety of the people within the facility. The special responsibilities associated with this work relate directly to the well-being and health of the patients and residents.

#### **RESPONSIBILITIES AND SKILLS**

Food service supervisors and technicians take a two-year course at a community college and at least one person on each shift is required to have a Food Safe Level 1 certification. Each health care facility also conducts in-house training that orients workers to the specific demands of the work within that facility.

Dietary orders for special needs patients – such as those with diabetes, heart conditions, allergies – or those who are recovering from surgery, are usually initiated by physicians and dietitians. These are often revised based on information from other health care workers who frequently monitor a patient's progress. This means some diets may be modified to take into account the needs of a patient who can't to chew (i.e., when a tooth is broken) or for some other reason is unable to eat solids.

Developing modified diets and keeping track of the “paper trail” associated with each patient is the job of the food service supervisor. The supervisor also monitors patients' eating habits and food preferences. Food is labeled according to patient and location within the facility, a task that is the responsibility of food service workers.

Each patient has a dietary chart that for each meal indicates their food dislikes, allergies or dietary restrictions (such as gluten, salt, sugar or lactose-free) and special food requirements such as whether the food needs to be thickened, minced or pureed. The food service worker must be familiar with each patient's restrictions, are held accountable for all food orders, and are expected to observe diet changes for individual patients.

#### **PATIENT CONTACT**

For most patients in hospitals meals are a high point in the day and a time for companionship and support. This is especially the case in long-term care facilities. In these facilities, food service workers still deliver food to individual rooms, they are able to interact with patients and to observe whether or not patients are actually eating the food given to them. This is an important function, particularly with elderly patients.

Many food service workers are frustrated by the increased pace of work that makes the meal rushed and often leaves little time for patient contact. The result is that more trays are coming back with uneaten food. In many cases the trays for patients with swallowing



difficulties or those who otherwise require more time to eat are left sitting on carts and are not distributed early.

Food service workers are particularly troubled by these changes in hospital routines and are conscious of the implications this has for patients. Even small dietary issues can be very important to people in long-term care facilities where the meals are the highlights of an elderly resident's day.

#### **HEALTH HAZARDS**

Working with patients who are frustrated or who have some form of dementia creates certain risks. According to one worker "people delivering food to the dining room must watch out for patients who strike out, or residents with Alzheimer's who throw food, glasses or whatever they can reach."

Because of the combination of the physical demands of the job and increasing workload, food service staff in long-term and acute care facilities have injury rates that are more than three times higher than those of the general labour force in B.C.<sup>32</sup>

## **IV. Key findings from the interviews with health care support workers**

**S**TAFF WHO PERFORM HOUSEKEEPING, laundry, trades, clerical and food service work in the health care sector are not simply duplicating the work performed in a hotel in a different setting. As can be seen from the previous discussions, the sheer technical sophistication of a health care facility requires different sets of skills and responsibilities than would be required in a hotel.

It is also crucial to recognize the distinct and different needs that are met in a hospital. In a hotel, the workers focus on the comfort of guests, but in a hospital the work is associated with improving the health outcomes of the patients. Health care support workers are acutely conscious of the health-related nature of their work and clearly do not see their work as simply a physical task unrelated to health care delivery. Patient care relies as much on the work of ancillary support workers as it does on doctors, nurses and technicians.

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**'Patient care relies as much on support workers as it does on doctors, nurses'**

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In addition, it is quite clear from the discussion that support staff have acquired substantial health care specific knowledge and skills related to the stability of their job tenure in the hospital. The wages and benefits paid to support workers and the job security provisions of their collective agreement encourage a stable workforce. An employment strategy, like contracting out, that undermined these wages and working conditions could lead to long-term problems associated

<sup>32</sup> Kitchen workers in long-term care facilities and acute care hospitals have injury rates of 15.5 per cent compared with 4.1 per cent for the average worker in the labour force. (Workers' Compensation Board, Statistical Services, special run, 1999). Their injuries come from repetitive strains from working on a tray line, cutting food during food preparation, and musculoskeletal strains from maneuvering heavy food carts.

with high turnover rates, lower quality and the need for an increase in administrative and supervisory staff to supervise and monitor contractors and to train and support inexperienced staff.

## V. Experiences with contracting out in other jurisdictions

**T**HE PREVIOUS SECTION SHOWED THAT support work in hospitals is not equivalent to hotel work and, therefore, should not be treated as though it is. It also showed that the work of support workers is an integral part of the efficient functioning of a hospital. This section will examine the experiences of hospitals that have treated these services as though they are “hotel” services and contracted out the work to private service companies. The experiences of U.S. hospitals will be examined because they have gone further than Canadian hospitals in privatizing the provision of these services. A discussion of the Toronto Hospital will also be included because it is a Canadian example of what can happen to public institutions when support workers are not directly employed by the hospital.

**THE U.S. EXPERIENCE:** Outsourcing or contracting out refers to the management technique of shifting various operations of an institution to the private sector.<sup>33</sup> The main reason institutions contract out is to either cut labour costs or to provide specialized expertise that regular staff do not have. A 1999 large survey of 340 acute care hospital executives in the U.S. by the Hospitals & Health Networks indicates that both clinical functions and support services are contracted out.<sup>34</sup> While the normal justifications for contracting out support services are that these are “hotel-like” functions that can be more cheaply performed by for-profit firms (as the Fraser Institute asserts), an examination of outsourcing in the U.S. indicates that these “hotel-type” services are not outsourced in most hospitals.

The survey, undertaken by the Hospitals & Health Networks, indicates that only four support services (out of 30 listed) are contracted out by the majority of the U.S. hospitals surveyed. These are pest control (86 per cent), laundry/linen (62 per cent), patient satisfaction measurement (61 per cent) and waste management (58 per cent).<sup>35</sup> Less than one-

### FAST FACTS

- **Surprisingly, “hotel-type” services are not contracted out in most U.S. hospitals**
- **Thirty-two per cent contract out food services and just 27 per cent housekeeping**
- **Toronto Hospital brings food services in-house to cure widespread patient dissatisfaction**

<sup>33</sup> For a discussion of the theory and practice of contracting out in the U.S. see Paul Seidenstat, ed., *Contracting Out Government Services, Privatizing Government* (Westport, CT; London: Praeger, 1999).

<sup>34</sup> Sunseri Reid, “Ninth Annual Contract Management Survey,” *Hospitals & Health Networks* 1999 73, no. 10 (October 1999). The clinical functions that are most frequently outsourced are equipment maintenance (58 per cent) dialysis (45 per cent), and anesthesiology (38 per cent).

<sup>35</sup> *Ibid.*, Figure 2. The figures in brackets indicate the proportion of hospitals that have contracted out this service.

third of the hospitals outsource food services (32 per cent) and just 27 per cent outsource housekeeping. Only 16 per cent outsource facility maintenance and virtually none outsource stores, admitting, and other clerical-related work. The survey indicated that the move to outsourcing “appears to have peaked.”

The primary motivations for outsourcing cited by executives are:

- to reduce costs (33 per cent);
- obtain specialized expertise (33 per cent); and
- allow the hospital to focus on “core competencies” (20 per cent).

On the other hand, those administrators who have decided not to outsource explained this decision on the basis of three main factors:

- they run the department well themselves (81 per cent);
- it is less expensive if done in-house (59 per cent); and
- they fear the loss of control over the function (49 per cent).

Caution about the benefits of outsourcing is certainly warranted, as is indicated by research on hospital “re-engineering” in the U.S. Re-engineering refers to changes in organizational practices. In the case of health care facilities it usually involves contracting out, although it can encompass a variety of dramatic changes in work processes that involve the reallocation of work flows, job responsibilities and production design.

To understand whether re-engineering in hospitals significantly improves the economic position of the organization, the American Hospital Association conducted a survey of approximate 30 per cent of all U.S. acute care hospitals with 100 or more inpatient beds.<sup>36</sup> The main findings of this study indicate that there is no reason to be optimistic about the benefits of re-engineering – “re-engineering appears to increase hospital costs relative to costs of competitors.”<sup>37</sup> In general the survey found that “re-engineering not only may not improve performance, but may actually be detrimental to it.”<sup>38</sup>

**THE TORONTO HOSPITAL:** In the fall of 1993 the Toronto Hospital (part of the university hospital network, Canada’s largest health care facility) began privatizing hospital support services. It was an ambitious attempt to reduce the hospital’s operating costs and to improve the quality and productivity of its services.<sup>39</sup> Senior management firmly believed that through outsourcing, “support service functions of the hospital could be carried out at less cost with no reduction in quality or levels of productivity.” Management of house-keeping was contracted out as were food services and stores.<sup>40</sup>

In its *Hospital Report 99*, the Ontario Hospital Association undertook a comprehensive survey of Ontario hospital efficiency. It looked at efficiencies in a broad sense arguing that,

<sup>36</sup> Stephen Lee Walston, Lawton Robert Burns, and John R. Kimberly, “Does Re-engineering Really Work? An Examination of the Context and Outcomes of Hospital Re-Engineering Initiatives,” *Health Services Research* 34, no. 6 (February 2000): 1363-1388.

<sup>37</sup> *Ibid.*, 1374.

<sup>38</sup> *Ibid.*, 1379.

<sup>39</sup> James A. Stonehouse, Alan R. Hudson, and Michael J. O’Keefe, “Private-public Partnerships: the Toronto Hospital Experience,” in *Strategic Alliances in Health Care: A Casebook in Management Innovation*, ed. By Peggy Leatt, Louise Lemieux-Charles, Catherine Aird, and Sandra Leggat. (Ottawa: Canadian College of Health Service Executives 1996): 137-147.

<sup>40</sup> *Ibid.*, 139.

“for too long our health care system has been measured from the rather narrow perspective of cost management alone, with less regard to clinical outcomes and patient satisfaction.”<sup>41</sup> As a result, patients were asked how satisfied they were with a range of services in the hospital, including support services. Questions about support services included queries about food quality and service. Patients were also asked about housekeeping, specifically with regard to the cleanliness of their rooms, bathrooms and the hospital in general.

Patients, on the whole, were not satisfied with the services at Toronto Hospital. Patient satisfaction with housekeeping (which had contracted-out its management) was rated as “below average” performance, while support services overall were considered to be at the very best, “average.” The survey is too blunt an instrument to be able to discern specific responses to issues like the quality of food or why housekeeping is considered below average. But clearly there are some grounds for concern.

In 1999 a survey of Toronto Hospital employees was also undertaken by hospital management to ascertain employee satisfaction. It was more decisive. Employees had a variety of questions with regard to leadership and direction, work involvement, work demands, teamwork, physical surroundings, financial rewards, career future and security and their commitment to the organization. The survey determined that staff below the senior management level were very unhappy with work in the facility, and the hospital was found to be below average in almost all areas surveyed. (The comparison group was a database of 100,000 employees in many industries across North America.)

In the reporting of the survey and as a guide to interpreting the results, the authors constructed an “Alienation Index” (AI) from Toronto Hospital responses in order to measure employee satisfaction. Low scores on the AI were deemed to be “highly predictive of employee withdrawal behavior such as voluntary turnover, absenteeism and third party intervention.”<sup>42</sup> A low score would be one that fell between -4 and -25 and would indicate a serious degree of alienation and acute employee disengagement. The vast majority of groups in the hospital had AIs that were very negative. The following are examples of the responses:

<b>GROUP</b>	<b>ALIENATION INDEX</b>
Medical staff physician	-12
Registered nurse	-11
Licensed Practical Nurse (LPN)	-7
Six to 10 years at hospital	-11
Clerical	-4
Technologist	-16
Technician	-8
Hospital assistant (support worker)	-15
Ward aide (care aide)	-9

<sup>41</sup> Ontario Hospital Association, *Hospital Report 99: A Balanced Scorecard for Ontario Acute Care Hospitals* (Toronto: Ontario Hospital Association, 2000).

<sup>42</sup> Organizational Studies Inc., *Total University Health Network*. (Organizational Studies Inc., October 1999), ii.

It is not clear – from either the patient satisfaction survey or the survey of employees – why the hospital performed so badly on these issues. Although the surveys do not link the poor scores directly to contracting out, the information collected in interviews with employees at the Toronto Hospital suggests that there is a very clear connection between the two.

In order to learn about the staff's experience with re-engineering and contracting out, several interviews were conducted with nurses and housekeeping staff at Toronto Hospital. Their analysis of the difficulties with contracting out and re-engineering focuses on food services and stores – the two support services that were contracted out in the mid 1990s.

### **FOOD SERVICE**

In 1994, dietary services were contracted out through the Toronto-based Bitove Corporation. According to one report this change would potentially save the hospital \$2.5 million, or half a per cent of its total operating budget.<sup>43</sup> While the cost savings are somewhat speculative, the deterioration in the food quality is not.

The contracting out of food preparation and delivery resulted in a “cook-chill” system that features highly processed and highly packaged food, the elimination of hot breakfasts, elimination of water delivery to patients and delays in meeting the needs of new patients with special dietary needs.<sup>44</sup> As one hospital worker noted, the highly packaged food is particularly difficult for old and sick people to open. Even a piece of toast is heat-sealed and many patients cannot open it. “The cold breakfast, often a bagel with peanut butter, is a horrible encounter for people with dentures,” one caregiver noted.

Often, food delivery schedules would go awry. One Monday, after a long weekend, the hospital ran out of food. Apparently the food supplier had failed to take into account that there would be a large intake of patients for surgery after a long weekend. The hospital, fortunately, had returned to making salads and sandwiches on-site after having contracted it out, so a very difficult situation was averted. However, even with this backup, one whole group in the hospital had no food for a day.

The Toronto Hospital is about to go through massive renovations and new building. The plan is to build new kitchens and bring back the dietary work in a dramatic reversal of the previous decision to contract out food services.

### **STORES**

An outside contractor handles all the stores supplying the three facilities in the university hospital network, including Toronto Hospital. The problems with the contracting out of stores relate primarily to the inability to have supplies when needed because very few supplies are kept in the hospital. Each floor has a quota of supplies that is insufficient for its

<sup>43</sup> Stonehouse, et al, op. cit., 140; *Financial Statements, The Toronto Hospital*, March 31, 1996. It is difficult to tell from the reporting whether this was the actual savings or the savings that were promised through the contract.

<sup>44</sup> CUPE, *Cooking Up a Storm: Shared Food Services in the Health Care Sector*, CUPE Research, 1995. In a conventional hospital food system meals are prepared a few hours in advance by staff within the hospital and held at the desired temperature (also called cook-hot-hold). The cook-chill method used by Bitove is radically different in that it allows for longer storage periods through controlled chilling and vacuum packaging process. While there is considerable debate about whether these processes actually reduce costs, it is clear that they do reduce food quality.

needs, so hoarding becomes routine. Quotas are allocated according to a complex system with penalties that ensure minimal supplies are ordered. Also, the supplier can determine substitutes for ordered items and even if no one on the unit can use them, they are still charged to the unit.

There are numerous examples of how the privatized stores system negatively impacts on patient care. In one case a doctor on a cardiac outpatient floor wanted the diapers of an incontinent patient weighed regularly in order to determine her fluid retention. The floor had run out of adult diapers and the stores supplier, when contacted, could not deliver more for 24 hours, and even that service would cost an extra \$100. Other floors could not accommodate the request, and the result was that this “procedure” was discontinued.

In another case the use of “blue pads” (i.e., for incontinence) that are crucial to patient comfort, have been curtailed. Now patients do not necessarily have clean pads when they should. As one worker said, “There have been no good times since 1994 when stores was outsourced.”

Evidence from the Toronto Hospital experience raises questions as to whether the benefits from contracting out outweigh the costs. Contracting out may, in fact, have been responsible for a reduction in patient and staff satisfaction. The recent reversal on contracting out of food services points in this direction.

As a McMaster University study noted, too often “Hospitals in both the U.S. and Canada have embarked on re-engineering strategies in the absence of empirical evidence that it is effective or safe for patients.”<sup>45</sup> Until there is further analysis on why patients and workers are so dissatisfied with their hospital experience, the re-engineering and contracting out experience that the Toronto Hospital undertook in 1994 should not be used as a template for other hospitals.

## VI. The privatization agenda

**T**HE FRASER INSTITUTE ADVOCATES OUTSOURCING hospital support services as a way of saving money. It does not argue that there are greater efficiencies to be made, rather, that one group of workers – health care support workers – are paid too much for what they do.

But this is not the end of the story or the whole story. The Fraser Institute is clearly intent on seeing that the entire hospital sector is privatized. Their recent report, *How Private Hospital Competition Can Improve Canadian Health Care*, claims “private hospitals can lower costs by avoiding the high wages associated with unionized public hospital employees in non-health care positions.”<sup>46</sup>

<sup>45</sup> Christel Woodward, Harry S. Shannon, Charles Cunningham, John McIntosh, Bonnie Lendrum, David Rosenbloom, and J. Brown, *Re-engineering in a Large Teaching Hospital: A Longitudinal Study, Working Paper Series* (Hamilton, ON: McMaster University, 1998), 98-1.

<sup>46</sup> Martin Zelder, *How Private Hospital Competition Can Improve Canadian Health Care*, On Public Policy Source Papers 35 (Vancouver: The Fraser Institute, 2000).

It is worth examining this assertion, particularly with regard to the expenditures of private U.S. hospitals on supposedly “hotel-like” services.<sup>47</sup> According to an editorial in the *New England Journal of Medicine* “no peer reviewed study has found that for-profit hospitals are less expensive [than not-for-profit hospitals.]”<sup>48</sup> The higher costs of profit-oriented hospitals are a result of greater expenses for administration and support services.

In fact there is considerable evidence to indicate that the privatization of hospitals leads to more expensive “hotel services.” According to one U.S. health analyst, U.S. hospital support services cost more per day or unit of service than they do in Canadian acute care facilities.<sup>49</sup> The lower costs among Canadian hospitals are predictable because of their global budgetary targets and single-payer system. But in addition to higher cost of processing claims in the U.S. system, the study also found that competition among American facilities for increased market shares result in “providing patients with more expensive hotel services.”<sup>50</sup>

The rush to privatization in hospitals has little to do with discussions of relative efficiencies or even cost cutting. The evidence simply does not support the notion that the benefits will be substantial and the costs considerably lower.

There are hidden costs of privatization and sacrifices to both patient health and staff morale that should make administrators very wary of calls for privatizing hospitals services. The splitting of clinical and nonclinical work where it has occurred (i.e., in Britain and in the Toronto Hospital) creates “institutional apartheid” that can be detrimental to staff morale and the care of patients.<sup>51</sup>

Outsourcing of support services is clearly a step in the market-driven direction the Fraser Institute advocates for hospitals, and they are following a clear strategy that is well-known to the supporters of privatization. The political path toward privatization is not easy, since people clearly recognize the value of publicly provided health care. But, according to one theorist of contracting out, the process needs to proceed in a step-by-step fashion in order to succeed, “Privatization efforts are most likely to proceed in an ad hoc, piecemeal, opportunistic fashion ... Rapid, comprehensive, wholesale efforts to privatize are not likely to be embraced by elected officials or by masses of voters.”<sup>52</sup>

## **FAST FACTS**

- **Studies suggest private hospitals lead to more costly “hotel” services**
- **Support services cost more per day in U.S. hospitals than in Canada**
- **Privatization supporters preach a piecemeal approach to avoid public opposition**

<sup>47</sup> It should be noted that the studies used by the Fraser Institute to support this claim are too dated to be considered appropriate for contemporary comparisons. According to Kevin Taft & Gillian Steward, the Fraser Institute also tended to misrepresent what the studies actually found. See Taft & Steward, *Clear Answers: The Economics and Politics of For-Profit Medicine* (Edmonton: Dubal House & Parkland Institute, 2000).

<sup>48</sup> Steffie Woolhandler and David U. Himmelstein, “When Money Is The Mission: The High Costs of Investor-Owned Care,” *The New England Journal of Medicine* 341, no. 6 (August 1999).

<sup>49</sup> Thomas P. Weil, “How Do Canadian Hospitals Do It? A Comparison of Utilization and Costs in the United States and Canada,” *Hospital Topics* (Jan. 1995): 10-22.

<sup>50</sup> *Ibid.*, 7.

<sup>51</sup> Paula Hall, “Warning Over Staff Transfer: Concern as City’s Super-hospital Draws Near,” *Coventry Evening Telegraph*, 18 March 1999.

<sup>52</sup> Paul Seidenstat, “Theory and Practice of Contracting Out in the United States,” in Seidenstat, *op. cit.*, 19.

The Fraser Institute seems to have heeded this warning and understands that the public will be alarmed if a political discussion of the entire privatization of the hospital sector is at issue. What they are intent on doing, at least in B.C., is to argue for the logic of privatizing hospital work one step at a time. Their first target is support work. If the arguments of the Fraser Institute are successful, it will be an incremental step toward the ultimate goal of the privatization of the hospital sector.

The Fraser Institute has pursued its privatizing objectives in the hospital sector on the basis of a seriously flawed report on the cost comparisons between support workers in hospitals and hotel workers. As this study has shown, the responsibilities, skills and conditions of work of hospital support workers are radically different from that of hotel workers and cannot be compared in the ways that the Fraser Institute and other supporters of privatization do. The benefits claimed from privatization appear to be driven more by ideological objectives than by an examination of the actual experiences of hospitals in either the U.S. or Canada.

In recent years, health care reform has increasingly focused on integrating the various aspects of health care. Health care providers recognize that each aspect of patient care is related to the whole program for the successful treatment of a patient. Any attempt to privatize and fragment aspects of that care runs counter to the notion that health care systems need to be integrated. Privatization of any part of the health care system will simply fragment care and put barriers in the way of teamwork.



Appendix I

**Wage Comparisons: Trades Occupations**

	Rate March 31, 2001			
	Electrician	Painter	Plumber	Carpenter
School Board <sup>1</sup>	27.05	26.43	27.03	-
BC Hydro (IBEW)	26.34	24.45	24.45	-
College (BCIT - CUPE)	25.07	-	23.86	23.12
Government (BCGEU)	23.84	22.18	-	-
Facilities Health Support Workers (HEU)	24.83	22.44	24.50	23.63
IUPAT <sup>2</sup> (construction)	-	25.21	-	-
IUPAT (residential)	-	23.25	-	-
IUPAT (industrial)	-	26.25	-	-
Carpenters Union <sup>3</sup> (comm. & inst.)	-	-	-	24.45
Carpenters Union (industrial)	-	-	-	26.35

<sup>1</sup> Electricians with IBEW 213; Painters with PATU; Plumbers with PPU.

<sup>2</sup> International Union of Painters and Allied Trades, district council 38

<sup>3</sup> Carpenters and Joiners United Brotherhood of America

**Wage Comparisons: Support Occupations**

		Rate March 31, 2001										
	Maintenance Worker III	Clerk V Purchasing	Secretary	Clerk II/ Receptionist	Switchboard Operator	Food Service Worker I	Food Service Worker II (Cook's Helper)	Cook I	Housekeeping Aide	Cleaner	Laundry Worker I	
School Board	-	22.87	19.29	18.12	17.00	-	-	-	-	18.21	-	
BC Hydro	-	21.47	19.68	19.68	19.68	-	-	-	-	-	-	
ICBC (OPEIU)	18.30	18.30	19.71	17.00	17.00	-	-	-	-	17.00	-	
College (BCIT - CUPE)	24.83	18.80	18.80	17.91	17.91	-	16.85	19.87	-	16.00	-	
Government (BCGEU)	18.49	20.87	18.49	17.41	18.49	18.38	18.49	19.64	16.90	16.90	16.90	
Health Support Workers (HEU)	19.78	21.13	19.03	16.97	18.98	17.41	17.07	19.53	17.19	17.19	17.17	
BC Ferries (FMWU)	-	-	-	-	-	16.77	19.24	20.67	-	-	-	
Delta Pacific Hotel	16.01	-	-	-	14.03	-	14.23	15.73	14.11	14.37	14.06	
Westin Bayshore Hotel	18.08	-	-	-	14.98	-	15.07	15.84	15.09	15.21	15.02	

School Board (CUPE Local 18) BC Hydro (OPIEU), ICBC (OPIEU), BCIT (CUPE), Government (BCGEU), Facilities Health support (HEU), BC Ferries (FMWU), Bartenders (Local 40), Westin Bayshore Hotel (Local 40)

# Appendix II

## Interview Methodology

Interviews for this study were conducted between September 2000 and January 2001. Much of the information about ancillary hospital support work was obtained through interviews with 30 hospital workers during six focus-group interviews in November 2000. The focus groups consisted of workers associated with housekeeping, clerical work, trades and maintenance, nutrition services and laundry work. These groups also represented workers in six acute care facilities, seven long-term care facilities and one laundry.

The acute care hospitals represented are Vancouver General Hospital, Royal Columbian Hospital, St. Vincent's Hospital, Surrey Memorial Hospital and Eagle Ridge. The long-term care facilities represented are Youville Residence, Cooper Place, Ridge Meadows, Fellburn Care Centre, Glengarry in Sooke and the long-term care facilities at St. Vincent's Hospital and Eagle Ridge. Workers at the Tilbury Laundry were also interviewed. The focus of interviews with HEU members was to gain insight into the work of support personnel with particular reference to the skills, effort, responsibility and working conditions.

In addition to HEU members, other hospital personnel and health experts were interviewed for information about health and safety issues, the work of hospital support personnel, training and education and information about contracting out at the Toronto hospital. These included the following:

- Senior infection control nurse at a B.C. acute care hospital;
- Medical microbiology physician at a B.C. acute care hospital;
- Health and safety physician, B.C. Workers' Compensation Board;
- Electrical foreman at a B.C. acute care hospital;
- Business agent, Hotel, Restaurant and Culinary Employees and Bartenders Union Local 40;
- Instructor, Building Service Worker Program, Vancouver Community College;
- Instructor, Institutional Aide Program, Vancouver Community College;
- CUPE local president, Toronto;
- Occupational health and safety RN, Toronto Hospital;
- OR nurse, Toronto Hospital;
- Two health care analysts; and
- Health analyst, Department of Soil, Water and Environment Sciences, University of Arizona.

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