CAPITALISM IS MAKING US SICK: POVERTY, ILLNESS AND THE SARS CRISIS IN TORONTO

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ABSTRACT

Purpose – For much of the first half of 2003 world attention was captured by news of a mysterious but deadly virus that was claiming lives in places as distant as Toronto and Beijing. In a matter of months there were around 8,000 infections and over 689 deaths related to severe acute respiratory syndrome (SARS). In my hometown, Toronto, 43 people died of SARS during the outbreaks of 2003.

Approach – This chapter examines issues of class and poverty in emergence of SARS. The chapter begins with a discussion of the political economy of the emergence of SARS, and its relation to the spread of the virus. It then discusses issues of public policy, and particularly neo-liberal cuts to social services and public spending, that set the stage for the SARS outbreak, influenced its impact and contributed to the failures of response in Ontario.

Findings – Through analysis of the lack of social resources available to working people in the province and the prioritizing of corporate, particularly tourism industry, concerns, the chapter illustrates how issues of class underpinned public responses to SARS, exacerbating problems.
The chapter concludes by giving attention to the need for social solidarity and community mutual aid.

Contributions to the field – The chapter shows the extent to which neo-liberal governments prioritize business security above the health and social security of workers and reveals some of the ways in which the pressures of capitalist social relations make people ill.

INTRODUCTION

For much of the first half of 2003 world attention from Hong Kong to Geneva was captured by news of a mysterious but deadly virus, similar to pneumonia, that was claiming lives in places as distant as Toronto and Beijing. As accounts of the virus’ growing toll became regular occurrences by February, severe acute respiratory syndrome (SARS) became part of the global lexicon. In a matter of months there were around 8,000 infections and over 689 deaths related to SARS. In my hometown, Toronto, 43 people died of SARS during the outbreaks of 2003.

The recent outbreaks of SARS in Toronto shone a harsh light on the inadequacies and outright failures of neo-liberal public health policies and practices. They also showed clearly the extent to which neo-liberal governments prioritize business security above the health and social security of workers. Even more than this, however, the SARS crises revealed some of the ways in which the pressures of capitalist social relations make people ill.

Public health officials first received warnings of SARS in early February and a full-blown crisis was emerging by March. By late April Ontario’s Conservative (Tory) Premier of the day, Ernie Eves, had not even recalled the legislature, which had been on hiatus since Christmas, to devise a plan for dealing with the various aspects of the crisis. For weeks the Conservative plan appeared to consist of little more than suggestions to ‘wash your hands’ or ‘continue to eat in Chinatown’. Governments only responded, and even then largely in terms of public relations, after the embarrassment of the late-April World Heath Organization (WHO) travel advisory and the threat of losses for tourist industry owners.

Even worse, the provincial government’s rush to assure tourists that the crisis was over following the WTO advisory seems to have played a major part in a renewed outbreak during the end of May. The nurses’ unions reported publicly that prior to the second outbreak their warnings to the government that it was too soon to let up on SARS went unheeded.
(Boyle & Mallan, 2003; Diebel, 2003). Clearly public relations, rather than public health, were at the forefront of Conservative concerns.

This chapter examines issues of class and poverty in emergence of SARS. These issues are also examined in relation to the public response to SARS in Toronto. Issues of poverty and illness are crucial in addressing emerging epidemics, especially in the global age in which diseases can travel the globe in hours rather than years. The chapter begins with a discussion of the political economy of the emergence of SARS, and its relation to the spread of the virus. It then discusses issues of public policy, and particularly neo-liberal cuts to social services and public spending, that set the stage for the SARS outbreak, influenced its impact and contributed to the failures of response in Ontario. Through analysis of the lack of social resources available to working people in the province and the prioritizing of corporate, particularly tourism industry, concerns, the chapter examines how issues of class underpinned public responses to SARS, exacerbating problems. The chapter concludes by giving attention to the need for social solidarity and community mutual aid in a context of emerging epidemics within capitalist globalization and questions why diseases and illnesses impacting poor people have received less attention and fewer resources than those largely impacting members of the global tourist classes.

SARS, ECOLOGY AND CAPITALIST POVERTY

In May 2003, researchers with the WHO traced the emergence of SARS to the Dongyuan market cages where various animal species, including threatened and endangered species, are regularly sold for human consumption. The SARS virus was found in six masked palm civets, a type of ferret that is served as food, as well as in a raccoon dog and a badger. Tens of thousands of civets are sold to restaurants in Guangdong each year.

Because of the poverty of market vendors, the markets are lacking proper facilities to maintain hygienic conditions. This along with the cramped quarters puts the animals under great stress, a condition that can activate coronaviruses. Such conditions also mean that it becomes more likely that viruses are passed to each other and to humans. These conditions make the markets susceptible to transfers of previously hidden viruses from animals to humans.

While experts went on to blame ‘outdated farming practices’ and over-population for the outbreaks of viral strains in China, the root cause is more
likely poverty and the conditions of work that go along with poverty. Unfortunately analysts have not looked more closely at this crucial factor.

Of course SARS is only one example of viral outbreaks related to environmental destruction and the intersection of ecological damage and poverty. Many viruses that already exist in nature are beginning to emerge and turn up in humans as a result of deteriorating ecological conditions, especially deforestation. Ebola in Africa and the Nepe virus in Malaysia are only two examples. As humans come to occupy newly opened natural areas or expand into wilder areas, they come into contact with previously inaccessible pathogens or their natural hosts.

MAKING ONTARIO SUSCEPTIBLE: IMPACTS OF NEO-LIBERAL RESTRUCTURING

Health care in Canada operates in a complex space where federal and provincial mandates intersect. Health care is considered a provincial responsibility but the majority of funding is provided by the federal government through the national Medicare program. The federal Liberal government has instituted, over three consecutive majority terms beginning in 1993, a massive reduction of funding transfers to the provinces. Beginning in 1995 the federal government removed regulations covering health care transfers that had previously ensured the funding went directly to health care. This move meant that monies that had previously been earmarked specifically for health care could now be spent on any other area the provincial government deemed necessary. This left Ontario’s governments free to apply $987 million in federal health transfer money to such areas as hydro cost overruns (Diebel, 2003, p. A8). Previously such moves would have been met with a financial penalty and a future loss of funds. This situation was compounded when former finance minister and former Prime Minister, Paul Martin, cut $6 billion from health care transfers to Ontario over four years between 1995 and 1999.

Most of the harm to Ontario’s health care system has been inflicted by the provincial Progressive Conservative (Tory) government. SARS, like the Walkerton tragedy before it, which saw several people die and hundreds become sick after privatization and cuts to water inspection contributed to E. coli contamination of the town’s drinking water, revealed the extent of the damage done to the health care system in Ontario by the Tories. When the Tories assumed power in 1995 under the leadership of Eve’s predecessor
Mike Harris, they pursued a stated policy of creating a crisis in public services in order to encourage privatization and cutbacks. Harris withdrew $1.3 billion from hospitals to underwrite a policy of tax cuts for the wealthy and corporations (Diebel, 2003, p. A1). With regard to health care, Harris maintained that Ontario employed too many nurses and worked to reduce staffing levels by laying off thousands of nurses. Between 1995 and 1999, 25,000 hospital positions were cut in Ontario (Diebel, 2003, p. A8). In addition, much of nursing in the province was casualized with 50% of nurses working part-time, often holding down two or three jobs at separate hospitals. Only 18 months prior to the SARS outbreak the government fired five leading laboratory scientists who worked with a Toronto reference laboratory unit that monitored coming infections and new disease threats. ‘Hospitals and public health units across Ontario relied on their work’ (Toronto Star, 2003b, p. A9).

Under-funded and under-staffed infection surveillance and control in hospitals played a part in the spread of SARS. Contaminated medical equipment and improper hygiene, which have been identified as emerging problems in Ontario’s hospitals, contributed to the progress of SARS (Nikiforuk, 2003, p. A23). The source of these problems resides partly in the privatization of such services in Ontario’s hospitals since 1995. ‘The evangelical search to save money in hospitals has also assisted and fortified microbes’ (Nikiforuk, 2003, p. A23).

The provincial government also downloaded public health costs onto already cash-strapped municipalities in 1998. At the time of the SARS outbreak, less than 83% of what is required in public health services according to provincial standards is actually being delivered in Ontario (Diebel, 2003, p. A8). Despite the concerns raised by SARS, the funding level is still below necessary amounts. Much of the responsibility has been passed onto municipalities that lack the resources to cope properly. In Toronto, the public health department requires $5 million to reach a full complement of staff (Toronto Star, 2003a, p. F6). Due to budget constraints resulting from chronic under-funding by the provincial government, the department was short 65 workers around the time preceding, during and following the SARS outbreak. During the crisis people were pulled off of other programs to assist with SARS and health workers had to be brought to Toronto from other areas of the province.

The Tories’ privatization of front-line health services played a major part in the province’s inability to keep up with the SARS outbreak. Likewise cuts to health care put systems under greater strain and left fewer resources to pick up the extra work (resulting in delays for people requiring other
services). Not only does Ontario’s health care system have little or no room for ‘surge capacity’, the insurance against unexpected outbreaks or emergencies, but it also lacks adequate capacity to meet ongoing needs, a problem that persists to the present day. SARS was a relatively narrowly confined illness, affecting primarily health care workers and family members of SARS patients, which should have been quickly and easily contained. Unfortunately few Ontario hospitals have the necessary number of infection-control nurses, as outlined by provincial recommendations. The diminished state of Ontario’s health care system, with inadequate facilities and staff levels for proper infection control, means that ‘the spread of infections such as SARS is inevitable’ according to the former chief of infectious diseases at Toronto’s Hospital for Sick Children (quoted in Diebel, 2003, p. A8). This already untenable situation was exacerbated by the response to the outbreak which saw the closing of hospitals to all but the most serious cases and the cancellation of hundreds of operations. Several otherwise avoidable deaths during the crisis were attributed to delayed or canceled operations (Diebel, 2003). Clearly public health care in Ontario requires a substantial increase in resources.

RESTRICTED RESPONSES

During the SARS outbreak in Toronto, provincial health authorities attempted to control the outbreak by declaring a health emergency and implemented widespread restrictions on the non-urgent use of hospital-based procedures at each of the Greater Toronto Area’s (GTA) 32 hospitals. Using a retrospective analysis of hospital admission data from the GTA prior to, during and after the SARS outbreak, two sets of investigators (Schull et al., 2007; Schabas, 2007) concluded that hospital restrictions resulted in only a modest decrease in the rate of admissions. Worse, hospital restrictions may have inhibited potentially seriously ill patients from seeking medical attention. Many people with serious conditions had surgeries canceled because hospitals were considered contaminated areas, and some of those people died. At three hospitals of the University Health Network, 1,050 surgical procedures were canceled as a result of SARS, including transplants, cancer and heart surgeries, hip and knee replacements and lens implants (Singer, 2007). As well, radiation, chemotherapy, dialysis physiotherapy and other treatments were canceled (Singer, 2007). Singer (2007) concludes that there may have been as many people who died from other illnesses who could not access hospitals as died from SARS.
In Toronto, thousands of people were placed in quarantine. Richard Schabas, Chief Medical Officer of Health for Hastings and Prince Edward Counties, argues that the use of quarantine during the SARS outbreak was ultimately ineffective as it is, counter to popular wisdom, in most infectious disease outbreaks. According to Schabas (2007) the practice not only wasted resources, but it also served to substantially heighten public anxiety and intolerance. Schabas concludes that SARS was not controlled through the use of quarantine but through the effective isolation of cases within the hospitals. Schabas (2007) argues that the experience of SARS makes clear that quarantine should have a very limited role in contemporary public health.

Singer (2007) suggests that restrictions of liberty, in the face of serious and imminent harm, must be relevant, legitimate and necessary, using the least restrictive methods reasonably available. It would appear that in the case of SARS in Toronto, these conditions were not met. Indeed they were not even approached. Singer (2007) also argues that society has a duty to ensure that those quarantined receive adequate care, are not kept in quarantine for unduly long periods and are not abandoned or psychosocially isolated. Again the experiences of quarantine in Toronto under SARS raise questions about the degree to which these obligations were fulfilled. While Singer (2007) also raises the need to eliminate economic barriers, such as income loss, that would prevent someone from following a quarantine order, it is quite clear that such economic supports were largely absent. Furthermore, restrictions were enacted against the informed analysis of front-line health workers.

These recent reports suggest strongly that dramatic measures used to address the outbreak, particularly quarantine, travel restrictions and the limiting of non-urgent use of hospital-based procedures, were largely ineffective, and more, even counter-productive. In fact, hospital restrictions may have inhibited patients who were ill with potentially serious illnesses from seeking medical attention. Schull et al. (2007) found that decreases in the admissions for serious acute conditions, such as gastrointestinal bleeding, heart attacks and pulmonary embolisms, were greater in the Toronto area, suggesting that people may have been inhibited from accessing specialized care.

Despite these conclusions, however, following the SARS outbreak, the Government of Canada passed the Quarantine Act of 2006 which strengthened the ability of health authorities to detain people believed to have been exposed to a communicable disease. In the view of government officials the legislation, and the imposition of travel restrictions, represents
a major step forward in developing preparedness in the event of a widely anticipated influenza pandemic. Critics such as Dr. Schabas counter that both the SARS experience and the particular biology of influenza should raise significant warning signs about the use of quarantine and travel restrictions during an influenza pandemic. In his view, not only would the costs of trying to establish quarantine be enormous, but also a system seeking to restrict travel and quarantine air passengers would be threatened with a descent into chaos (Schabas, 2007). Schabas argues that national borders are not, and indeed, never have been, important lines of defense against infectious diseases. Yet it might be noted that the focus on detention and restrictions on mobility fit well with the broader emphasis on border controls and detention that have characterized Canadian social policy, particularly with regard to immigrant populations, since the terrorist attacks of 11 September 2001.

Rather, for Schabas, the proper defense is found in sanitation and hygiene, overall health and proper general medical care. Other factors, such as the ready availability of immunization, antibiotics and antiviral drugs, also play important parts. Yet it is precisely areas of sanitation, hygiene and access to regular and suitable medical care that have been weakened by almost two decades of neo-liberal governance in Ontario. Indeed, cuts to social spending for the poor and unemployed leaving thousands of families without proper diets and nutrition, declines in adequate social housing stocks, reduced health care expenditures and the shortage of family doctors in the province, as well as the lack of public coverage for pharmaceuticals all contribute to a context in Ontario in which the population is left more susceptible to broad health problems.

SARS AND WORK

The problems caused by the lack of public health resources were compounded by the failure of any level of government to compensate workers who had to go under quarantine and the failure to compensate anyone who was not quarantined but thought they had symptoms and should stay home from work. That this failure played a part in the spread of SARS in Toronto, and in the spread of panic over SARS, was highlighted when an infected nurse from Mount Sinai hospital took the inter-city commuter ‘GO Train’ and Toronto Transit Commission (TTC), urban rapid transit, to work on 14 and 15 April because she could not afford to miss.
By mid-June, the province had still failed to increase hospital resources and staff. At St. Michael's hospital 30 extra health care workers were required for SARS duty during the second outbreak. Even double-time wages were not enough to entice many workers to put themselves at risk given the inadequacies of resources that remained. A Ministry of Labour investigation during the outbreak found St. Michael's, as well as North York General, to be in violation of the Workplace Health and Safety Act for having provided inadequate equipment and training to nurses, including SARS masks that did not fit. The hospitals responded by threatening mandatory work to deal with the SARS cases. Finally, during the second outbreak, after weeks of serving stress-filled overtime shifts and suffering some of the city’s highest infection rates, nurses, through their union, put forward a demand for ‘danger pay’. No amount of danger pay could make up for the tragic fact that SARS left two nurses dead while making dozens more ill.

Incredibly, other hospitals responded by laying off nurses. Lakeridge Health Corporation laid off 15 registered practical nurses, including 11 who were in quarantine at the time. Premier Eves responded to criticisms about the firings by claiming it was part of the province’s attempt to build a ‘flexible system’ that ‘would be able to move resources as we need them within the health-care system’ (quoted in Boyle & Mallan, 2003, p. A6). Indeed further layoffs were proposed as hospitals scrambled to make up a deficit of approximately $400 million. Of course the flexibilization of health care, a key aspect of Tory policy, had already placed the system in an extremely vulnerable position.

Singer (2007) suggests that under SARS Toronto health care workers were, for the first time in a generation, forced to weigh their obligations to care for the sick against serious and imminent health risks to themselves and their families. With dozens of medical workers, primarily nurses, contracting SARS, difficult choices confronted health care workers across the city in a context in which hospital administrations and the government only heightened the stress that those workers faced. Putting their lives at risk to help others, health care workers feared contagion for themselves and their families and being shunned by others who viewed them as potentially infectious (Singer, 2007). Many struggled with reduced human contact with sick and dying patients and the burdens imposed by cumbersome and uncomfortable equipment they were required to wear to protect themselves (Singer, 2007). Loss of work and disrupted work routines, without proper compensation or support, added to stress. Many more lost work as their hospitals restricted admissions.
Singer (2007) argues that, as health care workers have a duty to care, society and its institutions have a reciprocal duty to assist health workers. Policies in health care institutions should not penalize workers either financially, socially or emotionally. Workers must be compensated for loss of work on a dollar-for-dollar basis. As well information and support must be made available to workers, both so that they understand the risks they are facing and to ensure that their safety is regarded and protected as much as possible. None of these circumstances was adequately present during the SARS outbreak. Furthermore, health care workers’ duty to care must be met by a mutual respect for their need to care for themselves, both as a human right and in order to ensure that they can properly carry out their work.

Institutions have an obligation to present clear guidelines so that workers know what is expected of them and what support and assistance they can expect (Singer, 2007). Workers must also be rewarded or penalized for following sensible practices such as staying home when they are sick. Singer (2007) suggests that rather than sending workers home when fewer staff are needed, better use of people’s time and desire to help might be made in communicating with patients and their families by phone to help overcome the isolation and alienation felt when people are quarantined and loved ones have restricted access to each other.

Governments were also absent in offering assistance to workers suffering layoffs and reduced hours in industries, especially hospitality and tourism, negatively affected by SARS. As late as 27 May, Hotel Employees, Restaurant Employees (HERE) Local 75 was still requesting, unsuccessfully, meetings with federal Industry Minister Allan Rock and Human Resources Minister Jane Stewart. Local 75 president Paul Clifford noted: ‘There has been no additional funds from senior levels of government directed towards hospitality workers. No EI [employment insurance] funds, no waiving of the two-week waiting period for EI, no relaxing of EI regulations and many workers and their families are going under’ (quoted in McGran, 2003b, p. A6).

During the second outbreak more than 7,000 people were quarantined. Incredibly, compensation packages were still not made available. More than two months into the outbreak the federal Liberal government finally waived the two-week waiting period for claims. Unfortunately they did nothing to relax eligibility regulations, a factor which was particularly relevant given that many hospitality and restaurant workers are part-time and therefore not eligible to receive EI payments under the normally tight EI restrictions. As well it should be pointed out that EI payments do not cover full wages,
even for the already lowly paid workers in hotel and restaurant industries. Similarly, nothing was forthcoming to assist tenants facing evictions or people unable to make utilities payments due to SARS layoffs or work cutbacks (Goosen, Pay, & Go, 2003).

SARS AND CIRCUSES: TOURISM AND TORONTO'S ECONOMIC AILMENTS

That each level of government was more concerned with helping tourist industry bosses rather than workers was clear in who received compensation or subsidy packages. Provincial money has come as subsidies to capital, especially those involved in entertainment industries such as Mirvish Entertainment (producers of such theatre spectacles as The Lion King and Mama Mia) and Rogers Communications (owners of the Toronto Blue Jays baseball team and notorious for not paying their cable installers). Exclusive restaurants and hotels also received subsidies.

For the most part the federal Liberal government, which precipitated the crises in health care by gutting health transfers to Ontario by $6 billion, offered such ‘symbolic support’ as holding a cabinet meeting at an exclusive Toronto hotel, to and from which they were chauffeured with great haste. Other responses were little more than gimmicks, including the proposal to pay the Rolling Stones $10 million in public money to put on a ‘free’ concert. Ironically this was the same amount as the total federal relief package to compensate laid-off and quarantined workers and affected small businesses.

Tourism in Toronto had been ill for some time before the SARS outbreak. A spokesperson for the TTC, which runs the city’s subway and buses, noted that the TTC had experienced a general city-wide falloff in ridership prior to any word of SARS. This echoed independent research into TTC ridership declines and budget cuts (Munro, 2002).

Like the entertainment industry giants, however, the TTC was not about to lose an opportunity. Promoting downtown events among Torontonians, the Transit Commission urged residents to ‘find out what it’s like to be a tourist in your own town’. The TTC public address system broadcast messages from prominent Torontonians encouraging its 800,000 riders to ‘wine, dine, entertain and shop in Toronto’. Suggestions for being a hometown tourist included, in a familiar vein, going to the theatre, trying a new restaurant and, incredibly, staying in a hotel. These 20-s messages were broadcast every 15 min in 69 subway stations. So again capital’s cure
for whatever ails you is ‘go shopping’. This was, of course, reminiscent of George W. Bush’s plea for Americans to go shopping after 9–11.

SARS simply provided a fortuitous cover for governments at all levels to obscure the relation of government policies, and the whims of investors and speculators, to economic troubles in Ontario. In fact, manufacturing and retail are vastly more significant aspects of Toronto’s economy that have suffered from changes in global economies and government bungling.

Two key factors behind recent economic concerns have received almost no mention: the Canadian dollar and rising electricity costs. The dollar’s increase in value has played a far greater part in the tourism drop-off than SARS and has also affected demand in the United States, which takes 85% of Canadian exports. The dollar surged from a record low of 62.1 cents (US) in January to a six-year high of 74 cents (US) in May. The Tory deregulation of utilities has resulted in a doubling of electricity costs for many companies, raising costs to twice the levels in Quebec.

**SOME SURGERY REQUIRED**

Anger over the Tories’ part in mishandling the outbreak, as part of their larger mismanagement of services, played a part in the provincial elections at the end of 2003. The Tories suffered a devastating loss as the provincial Liberals captured one of the largest majorities in Ontario’s history. Tellingly, Premier Eves (now former Premier) canceled two prior election announcements, including one that had been planned for the week in which the second outbreak occurred, lest the election become a referendum on Tory health care policies. Anger over the Tory bungling of the SARS crisis was still running high, extending into their support base among suburban consumers in the regions surrounding Toronto, at the time of October’s election and likely contributed to the loss of several key Tory ridings in the city’s suburbs. Notably, health minister Clement, a major figure in the party, was among the casualties.

Now into a second term, the provincial Liberal government has failed to maintain its election commitment to restore funding and resources to Ontario’s health care system. This is probably not too surprising given the actions of the federal Liberals to undermine medical care in Canada over the last decade. Indeed the provincial Liberals, upon taking office, broke their promise to end a private–public hospital venture.
SOLIDARITY AND HEALTH: AN ALTERNATIVE GLOBALIZATION

Infectious diseases can now travel the globe quickly, in a matter of hours rather than years. In a globalized world the need for solidarity becomes crucial (Singer, 2007). This has long been a central theme of the alternative globalization movements that have emerged to mobilize for a globalization of social justice, fairness and equality rather than a globalization of ‘free trade’, markets and economic exploitation. Solidarity means working on the basis of mutual aid and support with others who are less powerful, wealthy or healthy (Singer, 2007). A key challenge of the global era is to understand and address the complex interconnections between globalization and health and to develop ways to overcome global health inequalities in different regions (Singer, 2007). Some of the instability and indeed trauma of globalization might be lessened through the nurturing of a global health ethic of solidarity. Health impacts are felt far more severely and do greater damage in poor, rural areas, but diseases can spread to wealthier, urban areas, as SARS showed, so those in wealthier centers have a self-interested, rather than purely compassionate, reason for developing an ethic of solidarity in dealing with health issues. Health, in privileged nations, is linked with health, or the lack of health, in poorer nations, especially as distinctions between domestic and foreign policy become blurred in the global age (Singer, 2007). Addressing this will, of course, require significant socio-political shifts.

As Singer (2007) suggests, along with solidarity we need transparency, honesty and good communication over health issues at global levels. Information sharing becomes a crucial part of ensuring the public good globally. This may involve the development of new governance mechanisms, and should, as alternative globalization advocates have argued, be carried out as part of a democratization process that includes greater citizen involvement in national as well as global governance. One example might include citizen fora and community panels, and transnational community organizations which bring together grassroots community members to share information and resources. This would involve the participation of health care workers but also unionists and workers in relevant industries such as food production, bringing people together across borders to share ideas and material resources that might allow for a restructuring of work and subsistence such that the causal conditions behind major outbreaks are avoided or lessened. It is not coincidental that SARS and, more recently,
H1N1 have roots in farming practices within conditions of poverty and insufficient resources. Other example would include the inclusion of health care workers and their union representatives within community policy panels.

Health must be viewed as a global public good, despite being treated nationally, regionally or locally (Singer, 2007). Local action and global action must be connected and coordinated. National governments cannot hide health information that might serve to protect others (Singer, 2007). Neo-liberal governance and the increased marketization of health care and food production, within multinational corporate contexts, have served to privatize health care and environmental regulations precisely at a time when private issues have globally public consequences. At the same time the neo-liberal emphasis on individualized health care and decreases to public welfare leave growing numbers of people susceptible to harm, without adequate resources to care for themselves and their communities.

Solidarity will mean addressing infrastructural needs globally. This will include the development of suitable public health laboratories, information systems, health communication capabilities, data gathering, storage and analysis capacities and epidemiological capacities (Singer, 2007). There is also a need to develop response capacities to deal with outbreaks, especially within poorer countries. This includes training in public health and an influx of resources to ensure health workers are properly deployed (Singer, 2007).

**BEYOND SARS: THE HIDDEN ILLNESSES OF CLASS**

The frantic, if inadequate, attention given to SARS, by both media and governments, highlights other class-related issues in Canadian health care. Other recent outbreaks in Toronto, such as tuberculosis, Norwalk virus and Hepatitis A, have received less attention because there is a sense among governments that these diseases are confined to poor and homeless populations and not likely to spread to the population at large. SARS had such impact because it affected suburbanites, consumers and, potentially, tourists.

Street nurses, those trained nurses who devote themselves to assisting homeless and street-involved individuals and tending to their many health issues, Crowe and Hardill (2003) note that the TB outbreak in Toronto shelters in 2001 was predicted by front-line health workers as early as 1994; yet the city and province did nothing to change the conditions – overcrowding and poor shelter conditions, lack of affordable housing and
community-based programs such as drop-in centers and unsatisfactory nutrition – that allow for the spread of such illnesses. Horribly, three homeless people died of consumption in Canada’s richest city in 2001 (Crowe & Hardill, 2003). Almost 40% of shelter residents have been exposed to TB (Crowe & Hardill, 2003).

The conditions that underlie the spread of TB are really the same as those that underlie the spread of SARS: the insecurity of capitalist economics which forces people to spend much of their lives working for wages lest they face the consequences of homelessness and hunger. Many workers know that they are a paycheck away from being homeless and too many of us are faced with the decision to pay the rent or feed the kids. Lack of access to and control over the necessities of life, which are owned and controlled by various profit-seeking bosses, and the forced compulsion to work to survive undermine the capacities of individuals and communities to make their health a priority.

As Crowe and Hardill (2003) affirm, ‘food, income, safety and housing protect people’s health. Simply stated, housing is protection from disease’. A guaranteed income might provide the same protection. Clearly a broad-based program for community health would include not only increased funding for public health departments, but also more affordable housing, improved conditions in shelters, nutrition programs, a minimum wage increase to a living wage level and increased welfare rates (or better a guaranteed income).

SARS, and the social response to it, brought together many of these crucial issues. It showed fundamentally and often starkly that emerging epidemics are about political economy as much as anything. SARS brought to the fore relations of inequality, power, poverty, democracy and governance and the distribution of resources within capitalist societies such as Canada in the global period. It showed that relations of power and inequality are central in giving rise to epidemics but also in inhibiting the capacities of people, such as health care workers, to respond adequately, despite their often heroic efforts. Even advanced health care systems are imperiled by persistent disparities in wealth and access to resources and decision-making processes. These are lessons that must still be learned and acted upon in light of ongoing threats of emerging epidemics in the current period. As more people are negatively impacted through economic crisis, and as economic ‘recovery’ programs retrench neo-liberal policies and re-distribute public resources to private capital, the lessons of SARS, and its social underpinnings, press even more forcefully upon us.
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