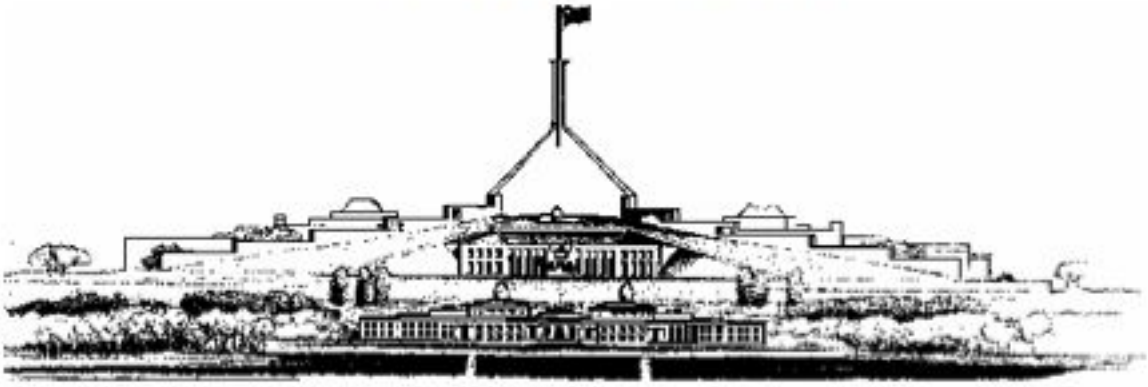
COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



HOUSE OF REPRESENTATIVES

GRIEVANCE DEBATE

Hospitals: South Australia

SPEECH

Monday, 23 August 1999

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

SPEECH

Date	Monday, 23 August 1999	**Source**	House
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Questioner		**Responder**	
Speaker	Cox, David, MP	**Question No.**	

Mr COX (Kingston) (5.00 pm)—There is a crisis in South Australia's public hospitals. It is a direct consequence of inadequate funding by both state and federal Liberal governments. The state's own Liberal Minister for Human Services, Dean Brown, has likened the state's public hospital system to the *Titanic* . He should know. As I will demonstrate, he was the captain who first steered the course for the iceberg. The crisis is being felt most severely at the Flinders Medical Centre, which is the major teaching hospital servicing Adelaide's southern suburbs. It becomes obvious to the public when the hospital reaches capacity. There are two consequences. The first is a very long wait in Accident and Emergency for admission to a ward, which may mean a long period on a trolley in a corridor. The second is that ambulances may have to be directed to other major hospitals like the Royal Adelaide.

On one infamous evening in July when Flinders had reached its capacity, arrangements were made to direct cases to the other major hospitals around Adelaide and, within a couple of hours, the whole hospital system became overloaded. A worse demonstration of the problem is to come. At 3 a.m. on Friday, 30 July, a 28-year-old man was admitted to the Flinders Accident and Emergency department. Two and half hours later, the patient died without having been seen by a doctor. It was the first time in 17 years that a patient had died at Flinders without being seen by a doctor. The Accident and Emergency department was staffed that night by four emergency doctors, two ward doctors and a paediatri cian, attending to 41 cases. It is a graphic and most regrettable example of the risks associated with an overloaded hospital system.

Overloading has become a frequent event at Flinders, particularly in winter. The usual causes are respiratory viruses and flu, resulting in many older patients with complex conditions requiring hospitalisation. To the extent possible, Flinders has permanently adapted to manage this overloading. Accident and Emergency has been completely redesigned, with solid walls between beds which face into a central glassed area from where patients can be monitored. The solid walls are to reduce noise, because the patients can expect to be there for an extended period.

In July, 175 patients had to wait 12 hours or more for a bed in a ward. At the other end of hospitalisation, a transport lounge is being set up for people on their day of discharge. It has nursing supervision and is somewhere people can wait for relatives to collect them so that they are not occupying a valuable bed in a ward. Flinders Medical Centre has also developed a new pre-admission clinic to reduce the length of stay in hospital of people requiring elective surgery. Patients are kept in Flinders only as long as is clinically necessary. One of the reasons Flinders fills to capacity so frequently is that it is relatively small for a major hospital. It has less than 430 beds. By comparison, the Royal Adelaide Hospital has 675 beds, the Royal Perth Hospital 700 beds and the Royal Brisbane Hospital 800 beds. Flinders did have 500 beds in 1993, but wards have gradually been closed because of budget cuts. It therefore runs with little capacity to do elective surgery. Only 20 per cent of admissions were elective cases, and only five per cent were not clinically urgent.

As a result of the July overload of the public hospital system, the Health Commission asked hospitals to reduce elective surgery for eight weeks. That of course means lengthening waiting lists for those procedures. The waiting time for elective orthopaedics was already about two years and, for elective heart surgery, around six months. If you are in severe pain, are relatively immobile and need a joint replacement, two years is too long to wait. If you require elective heart surgery, a six-month wait increases the likelihood that your circumstances will become urgent and quite possibly fatal. These are some of the real incentives for people to remain in private health insurance if they can possibly afford it. Unfortunately, if you are a pensioner requiring a knee reconstruction, you will have no option but to wait. Once you are admitted, whether it is to Accident and Emergency or for an elective procedure as a public patient, the treatment is absolutely first rate, and I hear nothing but praise for the medical staff. Nursing staff, however, are spread rather thin because of cost-cutting, so some of the attention relating to patient comfort may not be as fast or as frequent as it would have been some years ago.

The fundamental problem is that Flinders is trying to operate with a declining budget. In 1998-99, it received an extra $5 million to cover extra patients above its agreed workload. In 1999-2000, the only increase it has received is a small one to cover pay awards and inflation, but there is no funding for additional activity, and

demand is increasing by five per cent per annum. This year, Flinders has been told there is no extra money available for extra work and it must reduce expenditure by that $5 million. The only strategies available are cost reduction and activity containment.

The scope for non-clinical cost reduction is small. With a budget of about $140 million, the total value of the non-clinical support contract is only $5 million. The reduction in activity means shutting probably another 30 beds this year. For simple reasons of safety, the existing nursing and medical staff cannot be spread any thinner. One ward, 6B, has already been closed. The loss of its 16 beds is expected to save less than $1.5 million. Nurses at Flinders Medical Centre took the unusual industrial action of trying to work harder when they voted to continue to operate all wards, including 6B. Because of the safety factor, senior management broke the ANF picket line on 6B and removed the patients.

The health minister, Dean Brown, knows it is a problem. He has been to cabinet and asked for an extra $100 million for the public hospital system. I was told by a senior medico from Flinders last week that the minister was claiming he had taken the need for extra funding to cabinet three times. I can imagine how difficult it would be getting $100 million extra out of the state budget at the moment. But, given the circumstances, there is no good reason why the minister could not get $20 million, and that would make a substantial difference to the overloading problem.

Most of South Australia suspects that the reason no money is forthcoming is that the Premier cannot bear to give his old rival a win. Unfortunately, the Olsen-Brown conflict still stands as an impediment to good government in South Australia. But it was Brown as Premier who cut well over $100 million from South Australia's own expenditure on hospitals. The Commonwealth Grants Commission *1999 Report on General Revenue Grant Relativities* tells the story of South Australia's own source public hospital funding in constant 1997-98 prices: in 1993-94, the last financial year that state Labor was in office, $394 million; in 1994-95, Dean Brown's first budget as Premier, $355 million; in 1995-96, $355 million; in 1996-97, the year that Dean Brown was deposed by John Olsen, $270 million; and in 1997-98, the year of the state election when John Olsen loosened the purse strings to get re-elected, $346 million.

The same Grants Commission report showed that South Australia's public hospital Medicare base grant had gone up each year, in 1997-98 constant prices, over the whole of that period: in 1993-94, $330 million; in 1994-95, $336 million; in 1995-96, $342 million; in 1996-97, $346 million; and in 1997-98, $354 million. The state government has sought to put the burden for fixing the public hospital system on the Commonwealth by demanding an increase in its funding. There have been heated public exchanges between state Health Minister Brown and Commonwealth Health Minister Wooldridge. Mr Howard cannot see why the Commonwealth should increase funding for public hospitals when he says that the problem was caused by the states cutting them. That ignores the fact that he cut $312.5 million from public hospital funding in his first budget with a measure described as `Reductions in hospital funding grants to the states to offset cost shifting of public hospital related services'. Mr Olsen, along with other premiers, has bought into the health debate. There have been suggestions such as means testing Medicare, selling Medicare Private to raise funds for public hospitals and setting up a Productivity Commission inquiry into the health system.

Mr Howard has never carried a torch for Medicare, but I doubt that he would buy into these arguments at the behest of premiers who want only to take pressure off their own health budgets—at least not until after the next federal election. What the public can see is Liberal politicians fighting amongst themselves while the public hospital system falls apart. My constituents have a very good grasp of this issue. They know how Mr Olsen and Mr Howard can fund a decent public hospital system. When they talk to me about this problem, they have a long list of things that the state and federal governments are wasting money on, and it would be difficult to argue with their spending priorities.