Australian public health specialist:

"Financial cutbacks have lowered the standard of infection control" in Victoria

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"We now boast one of the best public health systems in the western world, due to record levels of investment in infrastructure..." Such are the claims of the Victorian Liberal government as it prepares to go to the polls next Saturday.

But in a letter written to one of the state's major teaching hospitals, a prominent public health specialist has warned that the quality of care in the public hospital system has declined so badly, that he is no longer in a position to defend hospitals sued by patients who have contracted infections.

Dr Ken Harvey, a senior lecturer in public health at La Trobe University and a former director of microbiology at the Royal Melbourne Hospital wrote: "I believe there is increasing evidence that severe financial cutbacks to Victorian public hospitals have lowered the standard of infection control, increased inappropriate antibiotic use and reduced the quality of health care. In addition, this situation has been compounded by managerial practices that have significantly undermined the morale of the staff that remain".

Harvey pointed out that two of his former colleagues at the Royal Melbourne Hospital, who were longstanding experts in pharmacy services, had been sacked after they were asked to implement a $500,000 budget cut to the areas they administered.

Harvey concluded his letter, declaring "In future, given the current parlous state of Victorian public hospitals, my medico-legal opinions will be for patients as plaintiff, not for hospitals and their defence".

A study conducted at Monash Medical Centre in Victoria over a seven-month period beginning in June 1997, showed that of 356 renal patients, 4.6 per cent had been colonised by Vancomycin Resistant Enterococci (VRE). Enterococci are gastrointestinal and genital tract bacteria, some of which are now resistant to Vancomycin, the most powerful antibiotic used to treat golden-staph. Results from the study, while not fully confirmed, indicate that the longer a patient remains in hospital, the greater the likelihood of picking up VRE. Renal patients who were colonised by VRE had been in hospital for an average of 17 days, compared to two days for those who were free from the antibiotic resistant germs.

The problem of bacteria becoming resistant to antibiotics is a global one. VRE was found to be present in the bowels of 2 percent to 17 percent of the general community in countries including the United Kingdom, the Netherlands, Germany and Belgium. In the US, VRE has become common, and those infected have a much higher death rate than those infected with antibiotic sensitive bacteria.

The overuse of antibiotics is a major cause of bacteria acquiring immunity. Natural selection occurs, and the resistant bacteria tend to survive and multiply. This is especially the case when a broad spectrum of antibiotic drugs is over-administered, as this enables bacteria to become immune to several antibiotics simultaneously.

Once VRE strains emerge in a hospital, their dissemination can occur through poor infection control. Hospital staff or patients can unknowingly pick up and spread bacteria from unclean surfaces. Intensive care, organ transplant, renal, haematology and oncology patients are most at risk from VRE disease.

Dr Harvey voiced his concerns to the *World Socialist Web Site* about the impact of cutbacks in the Victorian health budget on the hospital environment.

“The concerns I had about the use of antibiotics in hospitals, and the containment of new resistant germs were exacerbated when colleagues of mine were fired by the director of the North Western Network. They had said that service would suffer if this type of budget cut was implemented. They were sacked after saying this.

“There are two main ways to approach the problem [of VRE]. Firstly, the prudent use of antibiotics. There have to be audit guidelines, and pharmacists are crucial to this in order to record what takes place, and so compare the guidelines with what is actually occurring.

“Pharmacists on a ward talking to doctors play an enormously important role. But their jobs have been decimated by the cuts to funding in Victorian hospitals. Now [the government] has announced that there has to be another 20 per cent cut in this area, on top of what has already occurred.

“Secondly, infection control. Here too, someone who is overseeing the whole ward and exerts pressure on doctors and nurses to keep everything clean is so important. They monitor what is going on and introduce remedial action. Again, when you remove staff, there is no-one there to stand back and monitor the situation.

“The message we got at the Victorian Drug Usage Advisory Committee conference, where a large multi-disciplinary group of health professionals discussed the situation, was that many essential functions in the hospitals have disappeared. What you're left with is that the people on the ground—doctors, nurses and others—are coping. But it is only a matter of time. Nothing happens immediately. Sooner or later, with antibiotic usage getting worse, there is the possibility of a resistant germ causing a disaster.

“Hospital management say ‘How do you know that this will occur? You cannot say for sure that this will occur'. But if you keep cutting back, if you don't listen to the workers at the workplace, then sooner or later, like the situation that occurred with the explosion at Esso, a disaster will happen.

“If you put administrators in charge of a network with salaries of $200,000 and a possible bonus of $40,000 per annum, and they are on short-term contracts, then they are going to be keen to implement government policies. It is inevitable that they will want to downsize, and achieve their targets. They become disinterested in staff and the general well-being of patients. Within three years such an administrator is gone. They are not going to be there when the crisis hits. They won't be seen as responsible.

“One of the other problems is that with downsizing, there is no-one left to actually record what is going on. This is convenient for the government, as there is no way of actually monitoring what is going on, as research has been cut to such an extent.

“Twenty years ago, I worked under someone who was a bit eccentric. He would put on white gloves and do random tours of the hospital. He would check under beds, he would use a ladder to check various surfaces. He would say, 'dirt equals germs'. He would say to the cleaners, 'You are the most important people in the hospital'.

“The cut-backs to the cleaning staff have impacted on hospitals. Now we have contract cleaners in at 3am who are working to be cost-effective. It's just that it takes time for there to be established a hard outcome to relate the decline in cleaning standards with the increase in drug resistant germs. If you have 600 injured and sick people under one roof, they are going to be breathing out germs, they will shed skin particles, cough and sneeze. If a doctor or a nurse touches a surface, they can unknowingly spread something. It has to increase the probability of spreading infections, if the cleaning isn't as it should be”.