

# Australian hospitals lack ventilators and staff to deal with pandemic

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Last Thursday, the federal and Victorian state governments announced a \$31.8 million agreement with a consortium of local companies to produce 2,000 ventilators to enable hospitals to deal with COVID-19. However, the life-saving equipment will not be ready until July.

While the two governments hailed the announcement as a triumph for national-based manufacturing, it underscored the lack of urgently-needed pandemic-fighting equipment, and the staff needed to operate it, in Australia's hospitals.

Another alarming aspect of the announcement was that the federal government invoked “emergency” powers to allow its health minister to exempt ventilators from the usual safety and performance tests of the Therapeutic Goods Administration.

For weeks, federal and state governments have been promising to triple intensive care unit capacity. But modelling suggests there are not enough invasive ventilators—used to aid breathing in seriously-ill COVID-19 patients—to support such a surge.

Despite premature government and corporate media claims that the end of the pandemic is near, the number of COVID-19 cases in Australia continues to rise, passing 6,200, with 55 deaths. The New South Wales (NSW) Health Department previously predicted that in the coming months some 80,000 people in that state alone were likely to require intensive care beds. In neighbouring Queensland, the health department predicted 64,000 beds would be needed.

The ventilators jointly promised on Thursday by federal Industry Minister Karen Andrews, from the Liberal-National Coalition, and Victorian Jobs Minister Martin Pakula, from the Labor Party, would only represent an almost doubling of Australia's ventilator stocks.

An article published in the *Medical Journal of Australia* last week indicated the acute shortage of

intensive care unit (ICU) beds. It estimated that there are only 2,378 available intensive care beds in the public and private sectors. This equates to 9.4 ICU beds per 100,000 people. In Italy, where the coronavirus rapidly overwhelmed hospitals, there were 12.5 ICU beds per 100,000 people.

At the reported maximum surge capacity, the existing ICUs could support an additional 4,261 ICU beds and 2,631 invasive ventilators. Yet there was another problem. Even with ICU beds at maximum surge capacity, the journal article estimates that this would require up to 4,125 additional senior doctors and 65,758 registered ICU nurses.

Far from meeting this need, the federal government last week pledged \$4.1 million to e-learning provider Medcast to offer free online courses to 20,000 registered nurses, to train them to work in intensive care and high dependency units.

The Australian Nurses and Midwives Federation, the trade union that covers some 280,000 workers, welcomed “the government's strategy” on its web site. “This will maximise the capacity of experienced, registered nurses and prepare them to boost the intensive care nursing workforce as needed in dealing with the unfolding pandemic,” the union claimed.

In reality, in addition to the inadequate number of free places available, registered nurses must seek approval from their managers in order to undertake the courses. Registered nurses who do not qualify for free training will have to pay for it out of their own pockets. A four-day Critical Care Nursing Course with Medcast costs \$945.

Moreover, the course comprises just 32.5 hours of education. Medcast notes in its FAQ: “This is not designed to replace practical training delivered in the clinical setting nor is it designed to replace formal postgraduate critical care qualifications. It is an expectation that the nurses who complete this course will

go on to be supervised by more experienced HDU [high dependency unit] and Critical Care nurses and work as part of a team providing patient care.”

Reflecting staff shortages across the entire health sector, 40,000 former doctors, nurses, midwives and pharmacists whose registration ended in the past three years are being urged to return to the medical workforce. There is no indication that any training will be provided to these workers. It will be left to their employers to “support them to make a safe return to practice and to ensure patient safety.”

Preparations are being made also to hire students to bolster health staff. Without concern for the psychological or physical wellbeing of students, Prime Minister Scott Morrison’s government announced that restrictions would be lifted on some 20,000 international nursing students working in the health system, so they could work up to 40 hours per fortnight.

Many international students may have no choice but to take on this work, in order to remain in Australia. The government has refused to provide any financial support for the two million or more international workers and students who have lost their jobs and livelihoods as a result of the pandemic. Morrison last week said they could “return to their home countries.”

Acute staff shortages exist in the ambulance and paramedic services too. The Australian Broadcasting Corporation (ABC) reported recently that NSW Ambulance planned to recruit paramedic students. Charles Sturt University students were “to be hired on a short-term casual basis.”

Australian Paramedics Association spokesperson Alan Murphy told the ABC that students would be “put in a position where they’re unable to drive an ambulance under lights and sirens, but they’re also not in a position to be able [to] treat patients unsupervised either. So you’ve got a qualified paramedic in the front trying to drive and direct treatment unsupervised while the student is in the back with the patient.”

NSW Ambulance employs just 3,800 paramedics, who provided care to 1,224,060 patients in 2019, before the outbreak of the coronavirus. The pressure on paramedics to cover understaffing, can be seen in the 11 percent increase in overtime payments for paramedics between 2017-18 and 2018-19.

Reflecting the extent of understaffing and equipment shortages, Sydney Health Ethics last week published a framework “to help clinicians, hospital administrators and policy makers decide how to allocate clinical health

resources as they become scarce within a pandemic such as COVID-19.”

The framework referred to three groups who were to be excluded from ICU care:

“The first group is those who are likely to recover—they are expected to survive without access to the ICU, even if they would, in normal circumstances, be admitted and could benefit from it. The second group are those who are dying—according to the best available evidence they are terminally ill (e.g. they have advanced, inoperable cancer). They are to be given supportive care, including palliative care, but are not to be considered for ventilation etc. The third group are those who choose not to be admitted to the ICU.”

According to the framework, patients deemed eligible for ICU should be divided into high and low priority, with high priority given to those who “on the basis of their current medical condition, are highly likely to recover and benefit long-term from admission into the ICU,” whereas low priority is given to those who “may recover after admission to the ICU.”

Such guidelines raise the spectre of doctors, nurses and health officials having to decide who will live and who will die, matching the horrific scenes of Italy, Spain, the UK and the US.

The inability of the health care system to cope with the unfolding pandemic is the product of decades-long cuts to funding to public health services carried out under Liberal-National and Labor governments alike, with the trade unions repeatedly suppressing the opposition of health care workers.

Instead of directing funding toward preventing the spread of the virus and treating patients, the government has pledged billions to the banks, big business and private hospital owners. The Morrison government’s biggest corporate bailout—its \$130 billion wage subsidy for employers, backed by the Labor Party—equals the amount allocated to public hospitals over four years in the 2019-20 federal budget.



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