HOSPITALS AS CENTRES OF POWER

By David Thomas

What does a hospital exist for? The answer seems to be obvious and easy: For the care and cure of the sick. However, in the context of our course, we need to ask whether this answer is adequate. It might be remembered that earlier in the course it was stated that one effect of the rise of the Bio-Medical paradigm was to move doctors and hospitals to the centre of thinking about "health" (even though the activities of both are in fact, focused on ill-health).

Keep in mind that paradigms are not merely systems of thought - they also have power implications. In this reading, we use a case study to highlight that besides care and cure, hospitals are also centres of power - overt, covert and of power-free power.

In this regard, one crucial factor we need to note that with the introduction of increasingly high-tech and sophisticated care, hospitals have become enormously costly not only to build, but also to run. They are so expensive that governments in many States do not attempt to build new ones – they are simply unaffordable. For a good long time now, the aim has been to see that existing hospital resources are spread in a way that makes them accessible to the greatest number of people at a minimum cost (which is going to be horrendous, in any case).

South Australia – too many hospitals

This case study focuses on the situation of hospitals in South Australia, a geographically huge but thinly populated state. It only has 1.2 million people (Sydney has 4 million), 1 million of whom live in the capital city, Adelaide. The other roughly 200,000 people live in small towns scattered across the State.

While the State government provided large public hospitals in Adelaide, hospital services in the rural areas were mainly provided by private hospitals built and owned by local communities, many of them as war memorials. However, by manipulating funding formulas, the Federal Labor government in 1974 forced these hospitals to become public, which meant they fell under the control of the State government. That created financial problems because with a small population and a comparatively small economy South Australia is one of the poorer States in Australia.

It was now faced with a situation of having fully to fund country hospitals many of which, on purely rational planning grounds, had no reason to exist. Very often they were (and are) situated very near to each other, providing costly, duplicate services such as fully-equipped and staffed operating theatres.

Moreover, bed occupancy rates were low. Whereas big city hospitals usually run at just close to 100% full, many small hospitals were very often less than 50% full

and seldom or never over 70%. Even with a daily average of only 12 patients, a minimum level of staffing had to be provided, with at least three people on duty at any time. This meant that average bed-day costs were very high, and in turn that meant that these hospitals were (and are) much more expensive to run than city hospitals.

Rationalising hospital services.
It was a situation which, in the eyes of planners, cried out for the rationalisation and redistribution of resources. In the 1980s, the South Australian Health Commission introduced a policy on country hospitals aimed at freeing up funds for reallocation. While In terms of this policy, no hospital was to be closed, some country hospitals were to lose their expensive acute (serious illness) and surgical facilities if they were found to fall within the following criteria:
1. There were larger acute-care facilities situated nearby.
2. Their own provision of acute care facilities was on a low level, and
3. The cost of acute care facilities was high in comparison to nearby centres (*Adelaide Advertiser,* 20/6/88)

It was planned to act against at least ten hospitals on this basis. The first three targeted were those in the towns of Laura, Blyth and Tailem Bend. All of them were within 15 minutes driving time of larger, duplicate hospital facilities and removing their operating theatres, acute care facilities, and staffing them as if they were little more than nursing homes would, it was calculated, make the equivalent of around $5m dollars available for use elsewhere.

In the words of the Health Minister, Mr John Cornwall: "There was a completely rational argument for using them as casualty clearing stations, maintaining a local GP to staff a 24-hour emergency service while at the same time redistributing a relatively large amount of money to upgrade services across the State" (Author interview).

Government agrees
For these reasons, when he received the proposals for downgrading the hospitals from his Health Commission, Cornwall accepted them. On the basis of his experience of four years as Health Minister, during which time he had fought several very tough political battles, he believed that this was a relatively uncontroversial move and would meet with little resistance elsewhere (Author interview).

That proved to be true initially; this was one of the proposals which he did not have to fight for in Cabinet. The Premier, John Bannon, known for his conservatism and caution, gave his approval to the downgrading scheme. One reason for that was that the government, then in the hands of the Labor Party, was in a strong position. It had been returned with a record majority in the previous State election, and moreover the parliamentary seats covering the three towns were not "sensitive" in that they were all safe conservative electorates which at the best of times, yielded the Labor Party only about 40% of the vote.

In other words, acting against the hospitals was not going to cost the Labor Party anything, because these were "no hope" seats anyway. Thus, said Cornwall, he believed the whole scheme would be implemented in two months (Author interview)

However, once the proposals moved beyond the Cabinet arena, they were met with a tidal wave of protest. It quickly became clear that the Health Commission, Health Minister Cornwall and the Bannon government had grossly underestimated the opposition, which soon spread far beyond the three towns in question and began to use a range of power sources to thwart the government move.

1. The use of overt power

Combination power

After State Cabinet gave its approval to the scheme in May 1988, the communities in question rapidly organised themselves for a furious campaign of protest. Angry meetings, which drew up to 500 people, were held in both Blyth and Tailem Bend. An even bigger protest was held in Adelaide itself on July 1, when 3,000 people, accompanied by bush bands and rural symbols such as a sheep and sheaves of wheat, were marched behind a hearse to the parliament building.

The most spectacular protest had taken place before this on the Labour Day holiday during June, taking the form of an hour-long blockage of the Adelaide-Melbourne highway. Only an hour's drive from Adelaide, and therefore within easy reach of news media, it made an excellent news story and was given headline treatment, especially on local prime-time television.

Physical power

The fact that the government feared another kind of power being used became clear when the head of the Health Commission was sent to the towns to explain the scheme. He met with an overwhelmingly hostile, almost violent reaction. Subsequently, when senior Health Commission officers went to a meeting with the Tailem Bend hospital board to inform them that the funding for the hospital was about to be cut (*Adelaide Advertiser* 1/6/88), it was thought necessary to provide the officers with an escort of two police squad cars and a plainclothes officer to protect them from possible physical assault.

Protests continued virtually unabated even after the implementation of the decision. Later in July demonstrators picketed the Health Commission Offices in Adelaide, preventing workers from entering the building. Police had to intervene when scuffles broke out between the protestors and Health Commission employees who tried to break the picket line.

Network power

Protests were not confined to residents of the three towns. In May, the Country Women's Association presented a petition containing the signatures of 45,000 people opposed to the scheme. Other groups who voiced continuous opposition included the Country Hospitals Action Group, who combined their efforts with the

Rural Solidarity campaign, which incorporated another body called Community for Rural Education.

As mentioned above, the United Farmer's and Stockholder's Association commissioned the study by the National Institute of Labour Studies at the Flinders University into the economic state of the three towns. Local branches of the Australian Medical Association passed resolutions demanding that the decision be rescinded. The chairman of its Rural Health Committee predicted that the government would regret its decision and that people in the three towns would be disadvantaged medically and socially, while the quality of medical care would fall.

The opposition Liberal Party in the parliament kept up a vehement stream of criticism of the proposals, and promised to reverse them and restore the three hospitals to their previous position when it came to power.

Baby trouble

The most serious challenge came later in 1988 when a pregnant woman, Mrs Sandra Bowen, expressed her determination to have her baby in the Blyth hospital which, in terms of its downgrading, could no longer supply obstetric services. She sought a Supreme Court injunction restraining the Health Commission from reducing funds in such a way as to prevent the hospital from rendering "ordinary services".

The court refused to grant the injunction, and when the Blyth hospital board agreed not to proceed with an appeal after the Health Commission had threatened to cut all its funding if it did, it seemed that the Laura/Blyth/Tailem Bend hospitals battle was over, with the State Health Commission and Minister John Cornwall being victorious.

A battle won, the war lost

This however, was classic case of a battle won but the war lost, since the Health Commission's plans further to rationalise the country hospitals in South Australia were virtually abandoned after this case.

Not only had the opposition proved much greater than had been anticipated, but the position of the Labor administration itself was gravely weakened by the State election of 1989. Very probably the “bad press” it had received over the Laura, Blyth and Tailem Bend affair contributed to its change in fortunes in the election in which it lost so many seats that it was forced to act as a minority government in order retain power.

In that situation, neither individual ministers nor the Cabinet as whole were likely to take any action in the health care field which might further destabilise the government.

Thus the hospitals in Laura, Blyth and Tailem Bend were the only ones been affected by rationalisation scheme, the other seven originally targeted being left untouched.

It was a spectacular failure of policy and defeat for the State Labor government. What had gone wrong? The clear answer is that that government, composed of skilled and experienced politicians, had been surprisingly naïive, seeing the hospitals simply as places for the care and cure of the sick.

That they met with so much unanticipated resistance indicated that they had failed to take the covert power dimensions described below into account.

2. The fact of covert power

This, it will be remembered, is power that is not openly exercised or even apparent. However, its existence will generally deter other “players” in political games from taking action. The failure of the Labor government in South Australia to take the covert types of power described here into account, led to disaster for its hospital rationalisation policy.

Pride and emotion

This is a very important factor in relation to hospitals. Communities surrounding a hospital very often take a great interest in it and are proud to be associated with it. This is particularly true in country towns. the leading position occupied by the hospital is reflected in the saying that "if you are looking for a hospital in a country town, look for the hill," the position of the hospital on the highest point being indicative of its importance in the life of the community.

As has been noted above, many of the hospitals were war memorials and were founded and run as community efforts. That gave the communities added pride in them. Even after the government took over the hospitals, local people still saw them as “our” hospitals and were outraged by the attempts to downgrade them.

It might be noted that even in big city areas, communities living near to large hospitals also tend to take pride in that fact that to become involved in the life of the hospital as volunteers, to help with running of fetes and cake-stalls etc in aid of hospital funds. In other words, local communities often have strong emotional attachments to their hospitals and will oppose any attempts by government to close down, to move or simply to downgrade a hospital.

These kinds of community feelings are not readily apparent, but as the Laura/Blyth/Tailem Bend case proves, governments which ignore this kind of covert power, do so at their peril,

Financial power

Economic factors are an equally significant covert power dimension of a hospital. It has to be remembered that a hospital not only provides employment to a wide range of people, ranging from skilled surgeons to cleaning staff, but is also a major purchaser of goods and services such as food, on which local suppliers rely.

The country hospital is often the second largest employer in the town after the district or county council; importantly, it is one of the chief sources of employment for women in the district. Added to this is the fear that once the hospital has gone, the doctor will follow and then the local chemist.

During the contest over the Laura, Blyth and Tailem Bend hospitals, a study commissioned by the United Farmer's and Stockowners' Association and carried out by the Flinders University National Institute of Labour Studies under the direction of Professor Richard Blandy, found that the three communities were among the poorest in South Australia. The study said the move would be a "cruel blow" to the communities, which would result in the loss of their doctors *(Adelaide Advertiser, 4/4/88)* .

Residents of the towns themselves predicted that half of the 40-strong staff at the Tailem Bend hospital would lose their jobs, 24 jobs in the Laura hospital would go, while in Blyth it was feared that the hospital and the 27 jobs it provided, would disappear altogether (*Adelaide Advertiser, 25/5/88).* The numbers may seem small, but these would be very big losses in a country town in which other unemployment opportunities are virtually non-existent.

Learning lessons
Thus when the residents of Laura, Blyth and Tailem Bend acted to oppose the downgrading of their hospitals, they were defending their economic interests as much as the interests of patients who might use the hospitals. In turn, the way State government ignored this kind of covert power, led to the exercise of the several different types of overt power by the communities described above.

It should be said that perhaps learning from the lessons of this case, the much wealthier State government of Western Australia which faces the same geographic and demographic problems (1.2 million of its 1.9 million population lives in Perth), decided as a matter of policy , that it would not try to rationalise hospital services in the vast interior of the State. Instead, it sees the large sums of money which have to be used to keep those hospitals open as an economic subsidy paid by the rich metropolitan area to much poorer rural communities.

That's the rationalisation of the policy anyway. It also represents an unspoken recognition of the covert power of the communities in which small-town country hospitals are situated.

3. Power-free power in childbirth?
As has been shown earlier in this Course, the coming of the Bio-Medical model transformed the practice of medicine and moved hospitals to the centre of our "health" systems. This leads to several questions, as follows

1. If hospitals had remained as they had been throughout history until the beginning of the 20th century - "factories of death", mere hospices for the sick and dying poor – would they ever have generated the types of power

and politics that we see in this case study of the attempted downscaling of the Laura, Blyth and Tailem Bend hospitals?

2. Does the fact that, besides being places for the cure and care of the sick, hospitals are also centres of economic and political power, further demonstrate the dominant power of the Bio-Medical paradigm?

3. What influence does the power-free power of that paradigm have on our thinking about the Birthing Options we will be looking later in this Course?