Funding cuts in Tasmanian public hospitals

The Tasmanian budget papers show major funding pressures on the state's public hospitals over the forward estimates. Payments for actual patient care[1] will rise in nominal (dollar) terms by only 0.9% in 2016-17 and will rise by only 3.7% over the four years of the forward estimates (Table 1). Of particular note is the decrease in budget-estimate funding for emergency departments (-5.7%) and community and aged care (-3.2%). All of these nominal funding changes, both up and down, translate into serious falls in real funding when price inflation and other costs are taken into account. (Table 2). These cuts are occurring after many years in which revenue has failed to keep up with costs and demand. That squeeze on our hospitals and on hospital staff has intensified over the last two years. As will be seen in more detail in Table 2, these figures show the full effect of that situation over the forward estimates period.

Table 1: Budget estimate payments to the Tasmanian Health Service, recurrent expenditure, all sources, 2015-16 to 2019-20 ($000)

	2015-16	*2016-17*	*Change*	*2017-18*	*Change*	*2018-19*	*Change*	*2019-20*	*Change*
Admitted services	760 331	772 698	*+12 367 (1.6%)*	765 352	*-7 346 (-1.0%)*	762 657	*-2 695 (-0.4%)*	793 870	*+31 213 (4.1%)*
Non-admitted services	154 239	167 534	*+13 295 (8.6%)*	172 481	*+4 947 (3.0%)*	173 109	*+628 (0.4%)*	177 324	*+4 215 (2.4%)*
Emergency departments	122 114	115 194	*-6 920 (-5.7%)*	115 073	*-121 (-0.1%)*	116 715	*+1 642 (1.4%)*	119 447	*+2 732 (2.3%)*
Community & aged care	200 907	194 407	*-6 500 (-3.2%)*	189 461	*-4 946 (-2.5%)*	188 987	*-474 (-0.3%)*	191 327	*+2 340 (1.2%)*
Statewide & mental health	116 803	116 813	*+10 (0.0%)*	118 472	*+1 659 (1.4%)*	121 378	*+2 906 (2.5%)*	123 410	*+2 032 (1.7%)*
Forensic medicine	1 242	1 435	*+193 (15.5%)*	1 477	*+42 (2.9%)*	1 654	*+177 (12.0%)*	1 698	*+44 (2.7%)*
Total	**1 355 636**	**1 368 081**	***+12 445 (+0.9%)***	**1 362 316**	***-5 765 (-0.4%)***	**1 364 500**	***+2 184 (+0.2%)***	**1 407 076**	***+42 576 (+3.1%)***

Source: 2016-17 Budget and Forward Estimates, Department of the Treasury, Tasmania.

The nominal increase of 0.9% in recurrent public hospital funding In the coming fiscal year is, in real terms, a substantial cut. To calculate the size of that cut, we must take into account those factors determining the cost of hospital care – price inflation, long-term rates of funding increase to cover the costs of new drugs, technologies and increasing caseload.

1 This does not include major capital expenditure (such as hospital redevelopments) or funding for the 'One Health System' reorganisation.

Price inflation – which includes wages and the cost of replacing non-capital items – runs at a long-term average of about 3%.[2] On top of this is the cost of new drugs and technologies and increased patient caseload. This is measured by the constant-price rate of increase in recurrent expenditure, which in Tasmania grew by an average of 4.6% per annum for the decade 2003-04 to 2013-14.[3] The funding increase of only 0.9% means, therefore, a substantial real decline in the capacity of hospitals to fund services. This is exacerbated in the following two years.

Table 2: Estimated funding of Tasmanian public hospitals, showing nominal and real funding ($000) 2015-16 to 2019-20

	2016-17	*2017-18*	*2018-19*	*2019-20*	*4-year cumulative[(d)]*
Nominal (budget) funding	**1 368 081**	**1 362 316**	**1 364 500**	**1 407 076**	**5 501 973**
Change year on year (%)	**+0.9%**	**-0.4%**	**+0.2%**	**+3.1%**	**+3.7%**
Minus price inflation (3.0%)[(a)]	*-41 042*	*-40 869*	*-40 935*	*-42 212*	*-165 058*
Minus other costs (4.6%)[(b)]	*-62 932*	*-62 666*	*-62 767*	*-64 725*	*-253 090*
Estimated real hospital funding	**1 264 107**	**1 258 781**	**1 260 798**	**1 300 139**	**5 083 825**
Funding shortfall	**91 519**	**109 300**	**101 518**	**64 361**	**366 698**

(a) AIHW hospital & nursing home price index.

(b) Includes new drugs, new technology and patient caseload.

(c) Shows the difference between funding in nominal and estimated real terms.

(d) Shows the cumulative effect over the forward estimates (2016-17 to 2019-20) of funding in nominal v real terms.

As hospital costs continue to rise, they far outstrip the increases in nominal funding outlined in the 2016 budget. Over the four years of the forward estimates, nominal funding will increase by 3.7% but projected costs will increase by 34%.[4]

Table 3: Nominal (budget) funding increments versus estimated changes in hospital costs, 2016-17 to 2019-20

	2016-17	*2017-18*	*2018-19*	*2019-20*	*4-year cumulative*
Nominal annual funding change	**+0.9%**	**-0.4%**	**+0.2%**	**+3.1%**	**+3.7%**
Hospital annual costs change	**+7.6%**	**+7.6%**	**+7.6%**	**+7.6%**	***+34.0%***

2 Australian Institute of Health & Welfare, Index of government final consumption expenditure on hospitals and nursing homes.

3 AIHW, *Health Expenditure Australia 2013-14,* Table 2.13, page 26.

4 Total cost increases are projected at 7.8% p.a. compounded over four years.

Despite substantial cuts in nominal and real terms in under the current government and its predecessor, caseload in the state's main public hospitals has increased substantially. By March this year, Tasmanian public hospitals had 179 fewer full-time equivalent (FTE) doctors than in 2010-11, a decline of 17.6%. Over the same period, the number of weighted separations[5] increased by 17.8% and emergency presentations by 6.7%.

Table 4: Full-time equivalent doctors in Tasmanian public hospitals 2010-11 to March 2016

	Salaried medical officers	*Visiting medical officers*	*Total doctors**	*% change (all doctors)**
2010-11 (av)	977		1 018	-
2011-12 (av)	857		898	-11.8%
2012-13 (av)	771		812	-9.6%
June 2014	808	41	849	+4.6%
June 2015	766	41	807	-4.9%
March 2016	798	41	839	+2.7%
Total change (+/-)	**-179**	**0**	**-179**	**-17.6%**

** Assuming the number of visiting medical officers is stable.*

Table 5: Weighted separations and emergency occasions of service 2010-11 to calendar 2015

	Weighted separations	*% change*	*Emergency*	*% change*
2010-11	102 849	-	141 966	-
2011-12	106 138	+3.2%	143 864	+1.3%
2012-13	109 384	+3.1%	145 079	+0.8%
2013-14	119 803	+9.5%	147 803	+1.9%
2015*	121 125	-1.1%	151 489	+2.5%
Change +/-	**+18 276**	**+17.8%**	**+9 523**	**+6.7%**

** Calendar 2015*

5 A weighted separation is a completed episode of inpatient care, adjusted for cost and complexity. Usually, one separation equals one patient.

This has produced a massive increase in workload for clinical staff. A relatively minor part of the unstaffed increase in patient numbers has been made possible by the increased efficiencies realised through the current Commonwealth-sponsored process of clinical redesign. But a far greater proportion of the increased caseload has been met simply by staff working harder and with longer hours, and taking on responsibility for an ever-increasing number of patients. How long that process of increased staff productivity can deal with budget-enforced resource cuts is uncertain, but it cannot go on forever. The inevitable outcome is that the number of patients being treated will have to fall, along with funding.

The state government appears already to have foreseen this.

In the new National Partnership Agreement on Public Hospital Funding, signed at the recent meeting of the Council of Australian Governments, the Commonwealth agreed to fund state public hospitals on the basis of the number of patients being treated, rather than by the block-funding arrangements introduced in the 2014 Commonwealth Budget and due to take effect from 1 July 2017. The previous arrangement limited Commonwealth funding of growth in hospital expenditure to consumer price inflation, plus population growth. Tasmania's population is growing at about 0.4% a year and inflation is at 1.7%. This would mean Tasmania would receive a nominal increase of 2.1% a year in Commonwealth funding regardless of whether the state government's own contribution to hospital budgets, and the number of patients, went up or down.

In contrast, under the new arrangements, the Commonwealth will fund 45% of growth in the National Efficient Price,[6] and 45% of increased patient numbers, up to an overall annual limit of 6.5%. Unless patient numbers were to fall, any state would get more under the new deal than under the only one.

But a side-deal was struck at COAG to give Tasmania and the ACT what the Health Minister, Mr Ferguson, has called a 'funding guarantee'.[7] Formally, this is called the 'National Partnership on Addition Assistance for Public Hospitals'. Provisional estimates in the federal budget show Tasmania receiving $1.9 million in 2018-19 and $4.1 million in 2019-20.[8] The budget papers note that 'The Commonwealth will provide funding to Tasmania and the Australian Capital Territory for the *National Partnership for Additional Assistance for Public Hospitals* in the event that growth in National Health Reform Funding is lower than growth in CPI and population in a given year. The arrangements will be settled following further negotiations with Tasmania and the Australian Capital Territory'.

6 The National Efficient Price tracks movements in health price inflation (currently around 3%) plus costs of new drugs and new technology.

7 Media release, 4 May 2016.

8 Commonwealth Budget Paper 2, page 15.

A footnote in the budget papers says 'Funding is indicative only and will depend on final entitlements to National Health Funding from 2017-18 to 2019-20', leaving the option for Tasmania to receive more funding than estimated, and beginning earlier (in 2017-18 rather than the year later).

The Tasmanian government will do worse under the new deal only if growth in caseload plus price inflation is less than 2.1%. Basic health price inflation – which tracks the cost increases from year to year of existing items, including wages – is likely to take up the whole of that 2.1%. That means there will be no money for both new items (such as new drugs) and for more patients. There are only two ways of resolving this: for productivity to increase further with staff working even harder than they do now, or by reducing patient numbers. Because staff are already stretched to or beyond the limits of their personal productivity, and the state's two main hospitals already routinely operate at or above 100% capacity, reducing patient numbers is the only option open to hospital managers.

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June 2016