

THE IMPACT OF BUDGET CUTS
ON TASMANIAN PUBLIC
HOSPITAL PERFORMANCE

AN UPDATE

MARTYN GODDARD

MAY 2013

EXECUTIVE SUMMARY

The effect on elective surgery of the Tasmanian government's 2011 health budget cuts has been partly documented in previous reports. New data from the Australian Institute of Health and Welfare now provides a more comprehensive view of the impact of the cuts not only on elective surgery but on the entire public hospital system. Data for 2010-11 and 2011-12 can now be compared to show the performance and capability of the system before and after the cuts.¹

Generally, the data show that hospitals have met budget constraints not by improving their overall lamentable levels of efficiency but by reducing services.

Perhaps the most disturbing single aspect of the new figures is the sharp decline over the period in the number of doctors – particularly senior specialists – working in public hospitals. In 2011-12 there were 120 fewer full-time equivalent (FTE) doctors than there were before the cuts, a decline of 12.6%.

There are three reasons for this decline. First, hospitals have been cutting down their use of expensive locum doctors – many of them senior specialists – but have not fully replaced them with staff members. Second, some people who have resigned have not been replaced. Third, many senior doctors' salaries have been contained by giving them the right to work part-time in private practice. They remain on the hospital's books but the time they spend with that hospital's patients, or supervising junior staff, is greatly reduced.

The effective departure of a disproportionate number of senior medical and surgical staff has an impact not only on elective surgery patients but on the entire system. With fewer senior doctors to supervise their junior colleagues, the system now places more responsibility than ever on registrars and interns, which is unfair to them and potentially dangerous for patients.

The number of full-time equivalent nurses fell by 65. Previous data indicate that the decline in the head-count number may be substantially more than this: in the southern region alone, the nursing head-count fell in the period by 115. Those nurses remaining in the system are being required to work large numbers of double shifts and many hours of overtime, which has the effect of artificially boosting FTE numbers.

The impact of the cuts has not produced any decline in the numbers of clerks and administrators. The number of bureaucrats actually rose marginally, by 15 on an FTE basis.

In terms of basic economic efficiency – that is, what it costs to deliver a given service – the Tasmanian public hospital system is now the second-least efficient in the country rather than the worst, having been overtaken in the last year by ballooning costs at Canberra Hospital, which drives the ACT's figures. In Tasmania the main measure of efficiency, the cost of the average weighted separation (or service) remains as it was previously. In order to meet national efficiency benchmarks, this figure will need to be reduced by about 20%.

Average length of stay, a major driver of high per-patient costs, improved significantly between 2010-11 and 2011-12 but this only restores the levels of 2009-10 and is not evidence of a fundamental or systemic improvement in efficiency.

The capacity of the Tasmanian public hospitals to provide care to the people they serve remains the least adequate in the country and became worse between 2010-11 and 2011-12, in contrast with better average performance in the nation as a whole. The key measure of hospital accessibility, the

1. Unless otherwise specified, data in this analysis are drawn from the AIHW's *Australian Hospital Statistics* reports for 2010-11 and 2011-12. They are available in full at www.aihw.gov.au.

number of overnight separations (services) performed per 1000 population, dropped in Tasmania from 92.2 to 89.7, while rising nationally from 112 to 116.2.

The number of patient days per 1000 population, another key measure of capacity, fell in Tasmania from 651.5 to 606.5, while rising nationally from 751.7 to 770.6. The number of sub-acute and non-acute separations per 1000 population rose significantly over the two years by 12.5% but remain the lowest in the nation at 3.3 compared with 17 nationally.

Tasmania's purchasing of drugs became more expensive over the two years and remains the least effective drug buying system in the country. The cost of drugs per casemix-adjusted separation was \$326 in 2011-12 compared with \$245 nationally.

Purchasing of medical and surgical supplies became more effective but, again, remain the most expensive in the country. The per-separation cost was \$746 in Tasmania compared with \$471 nationally.

A procurement review is known to have been conducted within the Department of Health and Human Services but its contents remain confidential. Whether the Minister intends to accept and enforce all, or any, of its recommendations is unknown.

ACCESSIBILITY

Accessibility – the extent to which a hospital system meets the needs of the people it serves – is perhaps the most critical element of performance. One of the main measures of a system’s ability to provide services is the number of clinical and nursing staff: no hospital can run properly if it does not have enough doctors and nurses. Another measure is the number of services (or separations) for each 1000 people in the community.

The period immediately after the Tasmanian government’s 2011 health budget cuts was marked with substantial falls in the number of doctors and nurses. Until now, comprehensive data has not been available on the extent of this fall and the state government has not furnished it.

The most meaningful measure of staff numbers is the full-time equivalent (FTE) figure, rather than the head count. For instance, if a doctor moves from full-time to half-time work, the head-count figure will be unchanged even though the time available to treat public hospital patients has been halved. The following table shows what has happened to FTE numbers following the budget cuts. The number of doctor positions has fallen precipitously. There are three explanations for this. Hospitals have been reducing their reliance on expensive locums but have not recruited enough staff clinicians to replace them. Some doctors who have resigned have not been replaced. And many doctors have been allowed to take up part-time private practice, because the hospital cannot afford to pay their full-time salaries. These doctors stay on the staff books but are much less available to treat public patients.

Table 1: Average full-time equivalent staff, public acute and psychiatric hospitals, 2011-12

<i>FTE staff</i>	<i>2010-11</i>	<i>2011-12</i>	<i>Change</i>
Salaried doctors	977	857	-120
Nurses	2 801	2 736	-65
Diagnostic, allied health	565	554	-11
Administrative, clerical	1 095	1 110	+15
Domestic & other staff	1 066	1 092	+26
Total staff	6 504	6 350	-154

This has serious implications for the running of our hospitals. Without exception, the people who leave to set up part-time private practices are senior, fully qualified specialists: junior doctors – registrars and interns – cannot set up their own outside practices. This means that the system is increasingly run by less-experienced junior medical staff, with potential implications for patient safety when complex conditions must be dealt with, or when patients develop serious or catastrophic complications. Junior doctors under supervision can – and do – deal successfully with most run-of-the-mill cases. But when unusual or difficult situations arise, patients need an adequate number of fully qualified specialists who have seen such things before and know how to deal with them.

These part-private doctors will also be difficult to lure back to work full-time in the public system. Most can earn much more from their private work with less stress. Public hospitals may have to be prepared to pay these clinicians substantially more than they used to get in order to entice them back.

FTE nurse numbers fell by 65, but this probably under-estimates the impact on this sector. Previous data showed the nurse head-count in the Southern region (based on the Royal Hobart Hospital) alone fell in the period by 115, more than twice the FTE figure for the whole state.² The probable

2. Hansard, *Evidence to Legislative Council Government Administration Committee A*, Parliament of Tasmania, 16

explanation is that reduced nurse numbers have been partly made up by requiring those remaining to undertake double shifts and many hours of overtime. This practice is expensive and the workload being demanded of individual nurses is probably unsustainable. There is also a potential safety price to be paid by patients being treated by tired, overworked and stressed nurses.

According to a key measure of accessibility, the number of overnight separations per 1000 population,³ Tasmanian public hospitals deliver by far the least adequate care in the nation.

Table 2: Overnight separations per 1000 population, public hospitals, 2010-11 and 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11	114.5	111.3	103.8	111.4	118.7	92.2	128.2	189.4	112
Cf nat av	+2.2%	-0.6%	-7.3%	-0.5%	+6.0%	-17.6%	+14.4%	+69.1%	na
2011-12	120.4	113.4	109.6	114.9	122.4	89.7	128.2	190.7	116.2
Cf nat av	+3.6%	-2.4%	-5.6%	-1.1%	+5.4%	-22.8%	+10.3%	+64.1%	na

As the table shows, Tasmania’s delivery of hospital services has declined significantly both in absolute terms and in comparison with the rest of the nation. This poor performance cannot be attributed to the nature of the population: just the reverse. Tasmanians tend to be poorer, sicker and older than the national average and as such could be expected to need more public hospital services, not fewer. The only obvious explanation for the decline between 2010-11 and 2011-12 is the impact of severe state government budget cuts in 2011.

A similar trend is evident from other measures: it is clear that the impact of the cuts has not been confined to elective surgery, though this area has been hard hit. But determining the precise impact on elective surgery is complex. To find out what is going on, we have to look at three measures – total elective surgery admissions, elective surgery admissions from the waiting list, and the elective surgery separations per 1000 population. *Total admissions* for elective surgery have increased marginally, by 0.8%. But the number of patients *admitted from the elective surgery waiting list* have declined by 5.3% (from 32.6 to 30.9 per 1000 population). To understand the difference, we first need to remember that ‘elective’ refers to any treatment that can be delayed by 24 hours. ‘Elective’ surgery therefore includes many serious cases, including cancer and cardiac patients who necessarily have a higher priority than less urgent cases. By definition, someone on a waiting list is deemed to be able to wait, usually for much longer than 24 hours and sometimes for years. Urgent ‘elective’ cases are pushing out less urgent patients because public hospitals do not have the capacity to deal with both.

The situation becomes even more complicated, and worrying, when one looks at the decline in the number of operations being performed. *Elective surgery separations* (or services) have plummeted by two-thirds.

Table 3: Separations involving surgery (total and per 1000 population), public hospitals, by urgency of admission, 2010-11 and 2011-12⁴

	2010-11		2011-12	
	<i>Separations</i>	<i>Per 1000</i>	<i>Separations</i>	<i>Per 1000</i>
Emergency	6 328	12.0	5 902	11.1
Elective	44 905	81.0	13 945	25.6
Total	51 233	93.1	19 847	36.6

November 2012.

3. The measure of overnight separations is considered by the AIHW to be the most accurate way of comparing interstate performance. In Tasmania’s case, the other measures (including same-day separations) are similarly below the national average and by similar margins.

4. Valid interstate comparisons are not available.

One possible explanation for the difference in the rate of decline of total elective surgery admissions, and the number of actual services provided is the current high rate of post-admission surgery cancellations: a patient may have to have two or more admissions before receiving one service (separation). Seriously ill patients are known to be displacing less-urgent cases: this may also be relevant here. Because the raw separation figures do not show the average complexity or cost of the services being provided, it may be that a lesser number of more expensive and complex services are displacing a larger number of those which are cheaper and simpler. Whatever the explanation, this is a serious matter and shows a damaging decline in the capacity of public hospitals to provide adequate service to its population – a decline which coincides with state government budget cuts.

Tasmania's figure on the number of patient days per 1000 population is the lowest in the nation, reflecting the other data on the state's inadequacy in providing public hospital care. Tasmania was the only jurisdiction in which this number fell over the two-year period.

Table 4: Patient days per 1000 population, public acute hospitals, 2010-11 and 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11	748.6	782.4	672.1	737.2	789.5	651.5	916.2	1 554.8	751.7
2011-12	775.2	795.6	682.8	760.6	821.7	606.0	949.1	1 592.0	770.6

One area of relative improvement has been an increase in the very low rate of delivery of sub- and non-acute care, probably as a result of state and Commonwealth programs to divert less seriously ill patients away from expensive and inappropriate acute care beds. The number of separations increased markedly faster between 2010-11 and 2011-12 than in previous years.

Table 5: Sub- and non-acute separations, public hospitals, by annual percentage change

<i>Change (%)</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Av since 2007-08	8.5%	5.2%	11.4%	5.7%	8.9%	1.2%	1.1%	-10.6%	7.6%
Since 2010-11	6.4%	6.2%	22.6%	22.1%	10.3%	12.5%	-13.6%	-26.5%	10.6%

But the data also show there is a great deal more work to do in an area which has been neglected in Tasmania in the past. For both same-day and overnight patients, sub-acute and non-acute separations in Tasmania are by far the lowest in the nation. The areas particularly hard hit by comparison with other states are rehabilitation and palliative care. Overall, the rate of sub- and non-acute services available to Tasmanian patients is about a fifth that of the country as a whole.

Table 6: Sub- and non-acute separations per 1000 population by same-day/overnight status, 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Same-day	15.6	0.7	8.3	0.4	11.5	0.1	2.3	0.7	8.2
Overnight	8.5	9.5	9.1	9.3	6.9	3.2	12.4	5.1	8.8
Total	24.1	10.2	17.5	9.7	18.4	3.3	14.7	5.8	17.0

MEASURING WASTE

The key measure of basic economic efficiency in a hospital system is the cost per casemix-adjusted separation. This shows the cost of the average hospital service, weighted for complexity. In nominal terms, Tasmania's figure has increased by 2% over the previous period but, when hospital price inflation is taken into account, is likely to have remained essentially unchanged.

In the previous year Tasmania was the most economically inefficient system; it is now the second-most inefficient, overtaken by the ACT, whose costs are driven by a single institution, the scandalously expensive Canberra Hospital.

Table 7: Change in cost per casemix-adjusted separation, 2010-11 to 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11	4 904	4 508	5 323	4 996	4 854	5 913	5 401	5 645	4 918
2011-12	5 280	4 693	5 246	5 733	5 251	6 033	6 384	6 017	5 204
Nominal +/-	+7.6%	+4.1%	-1.4%	+14.7%	+8.1%	+2.0%	+18.2%	+6.6%	+5.8%

Source: AIHW

For this one year, Tasmania has turned in a relatively better performance than most other states which, with the exception of Queensland, have become less efficient than they were before. But Tasmania's costs remain unacceptably high and will need to be reduced by around 20% to meet the Commonwealth's new National Efficient Price on which federal funding is based. It is also worth noting that there have been a number of particular years in the past in which per-service costs have stabilised, only to resume their upward trend. It cannot be assumed, on the basis of one year's results, that Tasmania has begun a genuine and sustained journey towards efficiency.

The relative situation can be seen below in the results for 2010-11 and 2011-12:

Table 8: Cost (\$) per casemix-adjusted separation (excluding depreciation) 2010-11

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Medical labour costs	1 124	834	1 152	1 202	1 156	1 238	1 271	1 154	1 066
Non-medical labour	2 338	2 383	2 783	2 371	2 186	2 893	2 690	2 851	2 448
<i>Nursing</i>	1 243	1 158	1 389	1 143	1 249	1 461	1 409	1 728	1 250
<i>Other staff</i>	1 096	1 225	1 394	1 228	937	1 433	1 281	1 123	1 198
Other recurrent costs	1 442	1 291	1 388	1 423	1 511	1 782	1 440	1 641	1 404
Total	4 904	4 508	5 323	4 996	4 854	5 913	5 401	5 645	4 918
Cf national average (%)	-0.3%	-8.3%	+8.2%	+1.6%	-1.3%	+20.2%	+9.8%	+14.8%	na
Cf Victoria (%)	+8.8%	na	+18.1%	+10.8%	+7.7%	+31.2%	+19.8%	+25.2%	+9.1%

Source: AIHW

Table 9: Cost (\$) per casemix-adjusted separation (excluding depreciation) 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Medical labour costs	1 185	975	1 177	1 407	1 237	1 295	1 417	1 299	1 163
Non-medical labour	2 490	2 443	2 707	2 729	2 373	2 990	3 328	2 969	2 564
<i>Nursing</i>	1 320	1 271	1 338	1 323	1 396	1 460	1 857	1 788	1 336
<i>Other staff</i>	1 169	1 172	1 368	1 406	977	1 531	1 471	1 181	1 229
Other recurrent costs	1 604	1 275	1 362	1 596	1 642	1 747	1 639	1 749	1 477
Total	5 280	4 693	5 246	5 733	5 251	6 033	6 384	6 017	5 204
Cf national average (%)	+1.4%	-9.8%	+0.8%	+10.1%	+0.9%	+15.9%	+22.6%	+15.6%	na
Cf Victoria (%)	+12.5%	na	+11.8%	+22.1%	+11.9%	+28.5%	+36.0%	+28.2%	+10.9%

Source: AIHW

LABOUR COSTS

Because wasteful administrative and clinical systems make each service in Tasmanian public hospitals so much more expensive than elsewhere, the cost components for each service are commensurately higher. Some 70% of hospital recurrent costs go on staff, so labour costs are particularly important. Each patient's share of labour costs are higher than they should or need to be, so all categories are higher.

Table 10: Labour costs (\$) per casemix-weighted separation, public hospitals, 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Non-medical									
Nursing	1 320	1 271	1 338	1 323	1 396	1 460	1 857	1 788	1 336
Diagnostic/allied	347	412	373	353	285	314	392	380	366
Administration	361	284	356	438	292	450	526	364	346
Domestic & other	215	229	343	326	151	324	100	437	251
Superannuation	247	247	296	289	249	443	453	na	265
Total non-medical	2 490	2 443	2 707	2 729	2 373	2 990	3 328	2 969	2 564
Medical									
Salaried/sessional	630	731	961	1 054	856	1 006	902	1 150	797
Visiting MOs	248	70	63	172	185	2	301	97	147
Private patients	307	174	153	181	195	288	214	51	218
Total medical	1 185	975	1 177	1 407	1 237	1 295	1 417	1 299	1 163
Total	3 675	3 418	3 884	4 136	3 610	4 285	4 745	4 268	3 727

But some labour categories are used less efficiently than others. To find out where the relative inefficiency resides, it is necessary to compare Tasmanian costs with national average benchmarks. The following table shows where Tasmanian labour costs are higher than can be explained by a general inefficiency. Areas of concern include superannuation, administration costs, domestic and other staff, salaried doctors and the level of labour cost input for paying private patients in public hospitals.

Table 11: Labour costs per casemix-weighted separation as a percentage of national average, public hospitals, 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Non-medical								
Nursing	99%	95%	100%	99%	104%	109%	139%	134%
Diagnostic/allied	95%	112%	102%	96%	78%	86%	107%	104%
Administration	104%	82%	103%	126%	84%	130%	152%	105%
Domestic & other	86%	91%	137%	130%	60%	129%	40%	174%
Superannuation	93%	93%	112%	110%	94%	167%	171%	na
Total non-medical	97%	95%	105%	106%	92%	117%	130%	116%
Medical								
Salaried/sessional	79%	92%	120%	132%	107%	126%	113%	144%
Visiting MOs	169%	48%	43%	117%	126%	1%	204%	66%
Private patients	141%	80%	70%	83%	89%	132%	98%	23%
Total medical	102%	84%	101%	121%	106%	111%	122%	112%
Total	99%	92%	104%	111%	97%	115%	127%	114%

Tasmanian hospitals spend much more per service on administrative costs than any other jurisdiction except the ACT. The administrative labour cost component of each hospital service rose in the period from \$422 to \$450, an increase of 7.2%.

Table 12: Administrative labour cost per casemix-adjusted separation and as a percentage of non-medical labour costs, 2010-11 and 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11									
Cost (\$)	321	272	370	380	241	422	368	341	320
% + or - from national av	+0.3%	-15.0%	+15.5%	+18.7%	-24.7%	+31.9%	+15.0%	+6.0%	na
2011-12									
Cost (\$)	361	284	356	438	292	450	526	364	346
% + or - from national av	+4.3%	-17.9%	+2.9%	+26.6%	-15.6%	+30%	+52%	+5.2%	na

The unduly high cost of labour is not about how hard people work but how efficiently they are used. Nor is it about how much they are paid: salaries for Tasmanian public hospital staff are among the lowest in the nation.

Table 13: Average full-time equivalent salaries, public acute and psychiatric hospitals, 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Salaried doctors	158 016	178 408	189 571	229 063	185 119	180 466	205 525	232 484	181 950
Nurses	89 379	85 894	89 866	91 979	86 775	86 968	112 849	105 894	89 235
Other personal staff*	na	na	63 186	na	44 780	na	70 814	72 404	56 919
Diagnostic, allied	89 512	61 871	98 599	89 096	100 377	86 607	64 224	92 183	80 094
Admin/clerical	79 681	51 211	68 159	70 123	58 552	62 744	83 586	70 977	66 205
Domestic, other	70 150	68 752	56 406	63 624	45 066	53 536	40 500	62 948	63 289
Total staff	94 558	84 547	95 857	100 653	91 906	89 578	108 934	108 368	92 841

*For Tasmania, NSW and Victoria, data for 'other personal care staff' were not supplied separately and are included in other staffing categories.

LENGTH OF STAY

Tasmania's performance on the AIHW's relative length of stay index improved between 2010-11 and 2011-12 but when previous figures are taken into account, this apparent improvement disappears. This index is adjusted for casemix, which allows variation in the types of service to be taken into account. An index figure greater than one indicates that an average patient's length of stay is longer than would be expected. It can also be seen from the following table that index figures below one have been achieved in a number of jurisdictions, particularly in Victoria.

**Table 14: Relative length of stay index (directly standardised) for public hospitals
2009-10 to 2011-12**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10									
<i>Medical</i>	1.03	0.90	0.91	0.97	0.99	1.08	0.98	1.11	0.96
<i>Surgical</i>	1.10	0.99	1.05	1.08	1.08	1.04	0.96	1.49	1.05
<i>Other</i>	1.16	0.99	1.05	1.01	1.08	1.03	1.00	1.42	1.06
Total	1.06	0.94	0.97	1.01	1.03	1.06	0.97	1.25	1.00
2010-11									
<i>Medical</i>	1.03	0.90	0.90	0.96	1.01	1.13	1.02	1.10	0.96
<i>Surgical</i>	1.10	0.98	1.02	1.09	1.06	1.06	1.00	1.49	1.04
<i>Other</i>	1.15	0.99	1.05	1.02	1.06	1.04	1.06	1.22	1.06
Total	1.06	0.93	0.95	1.01	1.03	1.10	1.02	1.24	1.00
2011-12									
<i>Medical</i>	1.04	0.90	0.86	0.96	1.01	1.07	1.03	1.10	0.96
<i>Surgical</i>	1.10	0.97	1.01	1.09	1.07	1.04	1.07	1.54	1.04
<i>Other</i>	1.18	0.98	1.00	1.02	1.04	1.02	1.09	1.35	1.07
Total	1.07	0.93	0.92	1.01	1.03	1.06	1.05	1.26	0.99

This measure is important for economic efficiency. Most of the cost of a given patient service comes from that patient's share of total salary costs. In Tasmania, though staff salaries are mostly lower than the average, the per-service salary cost is very high. It should not be assumed that shorter lengths of stay are detrimental to the patient: just the reverse. Although care must be taken to ensure patients are not discharged 'sicker and quicker' than they should be, few patients want to stay in hospital longer than they have to. There is a large body of evidence to show that patient satisfaction ratings and health outcomes improve when clinically appropriate administrative initiatives reduce average lengths of stay.⁵

5. Neville Board, Gideon Caplan, 'Implications of decreasing surgical lengths of stay,' *Australian Health Review*, vol. 23, no. 2, Canberra 2000.

PURCHASING

Inefficient purchasing procedures are responsible for wasting millions of dollars in each year's Tasmanian public hospital budgets. Some efficiencies have been made over the period in the purchasing of medical and surgical supplies but the amount spent per patient service on drugs increased both in absolute terms and when measured against the national average. For drugs and supplies, Tasmania is the least efficient purchaser in the nation.

Table 15: Cost (\$) per casemix-adjusted separation of medical/surgical and drug supplies in Australian public hospitals, 2010-11 and 2011-12

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Medical supplies (2010-11)	540	390	582	332	335	780	467	414	471
Medical supplies (2011-12)	574	400	572	380	349	746	518	435	491
Drug supplies (2010-11)	254	239	257	267	238	317	144	243	250
Drug supplies (2011-12)	235	243	243	286	244	326	156	247	245

There is no good reason for this to continue. The excuse most frequently proffered is that Tasmania represents a small market and cannot adequately pursue discounts for bulk when dealing with suppliers. But we are larger than the ACT and the Northern Territory, which are far better purchasers than we are.

A procurement review is known to have been conducted within the Department of Health and Human Services but its content remains confidential. Whether the Minister intends to act on its recommendations is unknown.

If Tasmania formed a comprehensive purchasing alliance with Victoria, both states could use their combined purchasing power to force much better deals from the makers of drugs, therapeutic devices and laboratory supplies. If this was done, there is no reason why Tasmania's costs would not then fall well below the national average. Many millions of dollars would be saved which could be reinvested in treating patients.