

ELECTIVE SURGERY PERFORMANCE IN TASMANIAN PUBLIC HOSPITALS

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MARCH 2013

EXECUTIVE SUMMARY

Delivery of elective surgery in Tasmanian hospitals is the least adequate in the nation. Analysis of new data from the Australian Institute of Health and Welfare shows that, measured by almost all performance criteria, Tasmania under-performs all other states and territories.

In their attempt to cope with the demands placed upon them, the state's inadequate and overstretched public hospitals concentrate on the most urgent cases, particularly those patients for whom long delay might be life-threatening. Elective surgery is defined as anything that can be delayed for 24 hours or more. This analysis now confirms what has until now been known only in anecdote: that unless the system improves dramatically, hundreds of patients on elective surgery waiting lists – many of whom are in constant pain and distress – will never receive their operations unless their condition deteriorates so far as to constitute an emergency.

Category three comprises the lowest-urgency cases. The clinically recommended standard demands that they be treated within a year. At the end of 2011, 1050 of the people in this category 3, had been waiting for longer than that: that means their names had gone onto the list in 2010 or earlier, in some cases years earlier. The new figures show what then happened to the 105 patients who comprised the 10% of category 3 patients who had been waiting the longest.

By the end of 2012, 98 of them (93.3%) remained on the list. This compares with none in NSW, Victoria, Queensland, South Australia and the ACT. As there are many reasons for removal from the waiting list including death, going private and moving interstate, it is probable that none of the seven patients removed from the list during 2012 was actually treated in a Tasmanian public hospital.

The data do not provide precise figures on patients in the second longest-wait decile but the figures indicate it is unlikely that they have a significantly greater chance of ever receiving their operations. Some hundreds of people, then, who are currently on the waiting list for elective surgery are have a chance of being treated that is close to zero.

Other data show the overall situation to be even worse. The national figures only count people who have been placed on a waiting list by a surgeon. But newly released figures show about 11,000 Tasmanians, believed by their GPs to be in need of surgical care, have not even been able to have their first consultation. Thus, they remain off the official waiting list and are not counted. This also does not count, of course, those people whose GPs have not bothered to refer them to a public hospital specialist because they know they have little chance of being treated or even seen. The number of people in this category is entirely unknown.

It is not possible from the statistics to reach a firm conclusion about how many people in Tasmania are unlikely to be able to secure surgery for which they have a demonstrated clinical need, except to observe that it is more likely to be in the thousands than in the hundreds.

The situation is by far the worst in the state's two major hospitals, the Royal Hobart and Launceston General. This has created a three-class system in Tasmania, reminiscent of trains and ships in the 19th century. In the first class are those who can afford to have their operations in a private hospital. In the second class are people in the north-west of the state, where waiting times are much shorter than in the two major hospitals; and in the third class is everyone else.

Budget cuts announced in the 2011-12 Tasmanian budget involved cuts to elective surgery funding in the state's public hospitals of \$25 million in 2011-12, \$32 million in 2012-13 and \$31 million in 2013-14. The result was a major reduction in the numbers of elective procedures being performed, substantial reductions in the numbers of doctors and nurses, and a blowout in waiting lists, particularly among low- to medium-acuity patients seeking such operations as joint replacement and cataract extractions. This added to a system which was already unable to meet the demands placed

upon it, partly because of a lack of funding and partly because the economic efficiency of the state's major public hospitals is the worst in the nation.

The most recent budget included a partial turnaround in overall health cuts but it is not possible to tell, from the government's announcements, precisely how this will affect elective surgery. The main state-funded measure on elective surgery outlined by the Health Minister, Michelle O'Byrne, was an increase of \$4 million during 2012-13 for endoscopy and elective procedures.

The matter is further complicated by the injection of Commonwealth money through various programs. The state government has at times sought to take credit for this extra money, which in fact represents a significant cost-shift from Tasmania to the Commonwealth.

But the measure of most importance is the effect on patients. New figures from the Australian Institute of Health and Welfare on elective surgery performance around Australia for the whole of calendar 2012 allow comparisons to be made for performance before and after the cuts, and between Tasmania and other jurisdictions.

The picture is a depressing one.

Across the board, admissions for elective surgery fell by 8.9% between 2010-11 and calendar 2012 but the sacrifice was concentrated largely among patients in the lowest urgency category. Many of these patients have already been waiting for many months and, in some cases, for years for such procedures as hip and knee replacements, cataracts, gall bladder operations and haemorrhoid procedures. Although these patients are categorised as low-urgency, many are in constant pain and all are experiencing major and extended distress.

The severest impact was among orthopaedic patients: there was a decrease of 30.4% in admissions for hip replacements and an increase in median waiting times of 33.5%. Among patients seeking knee replacements, a reduction in admissions of 33.3% resulted in an increase of 44.8% in median waiting times.

Waiting times in Tasmania were the longest in the nation. In 2011-12, 9.4% of all elective surgery patients had waited for longer than a year for their operation compared with 2.7% for the nation as a whole.

The most recent AIHW figures, for calendar 2012, reported on the progress of all states and territories in meeting targets set by the Commonwealth under a program to improve performance. Tasmania failed to meet any of its targets and in some categories fell below its 2010 baseline performance. This is despite having by far the least demanding targets of any jurisdiction.

BACKGROUND

IN HER 2011-12 budget speech on 16 June 2011, the Premier and Treasurer, Lara Giddings, outlined cuts of \$100.2 million to that year's Health and Human Services budget. Of this, \$75.3 million was to come from health. Although the Minister for Health, Michelle O'Byrne, initially said that these cuts would be made without affecting frontline services, this turned out not to be the case.

In October 2011, the government announced that the budget savings could not be achieved without substantial cuts to services, which would be concentrated largely in elective surgery. The cuts to elective surgery were likely to be almost \$88 million over three years and are listed below.¹

Table 1: Projected budget cuts to elective surgery (\$'000), Tasmania, 2011-12 to 2013-14.

	2011-12	2012-13	2013-14	Total
Southern Area				
Reduce elective surgery volumes	10 700	17 300	17 300	45 300
<i>Total Southern Area</i>	<i>10 700</i>	<i>17 300</i>	<i>17 300</i>	<i>45 300</i>
Northern Area				
Reduce elective surgery volumes	8 500	TBA (8 500)	TBA (8 500)	TBA (25 500)
Reconfigure surgical ward 4D	2 200	2 277	2 277	6 754
<i>Total Northern Area</i>	<i>10 700</i>	<i>10 777</i>	<i>10 777</i>	<i>TBA (32 254)</i>
North West Area				
Reduce elective surgery volumes	2 376	1 728	1 056	5 160
Reallocate beds across NW	1 015	2 029	2 029	5 073
<i>Total North West Area</i>	<i>3 391</i>	<i>3 757</i>	<i>3 085</i>	<i>10 233</i>
Total	24 791	TBA (31 834)	TBA (31 162)	TBA (87 787)

Source: DHHS. Figures in brackets assume 2011-12 cuts in Northern Area being replicated in following years.

If it is assumed that, at current prices in Tasmania, an average elective surgery procedure costs about \$11,500, a budget reduction of \$88 million would result in about 7,600 patients not being treated. If the cost of the average procedure was reduced to around the national average – about \$10,000 – the number who could have been treated for this money would be 8,800. In addition to this is an increasing backlog of unmet demand as waiting lists lengthen.

In the 2012-13 budget, the government announced 'savings relief' across the DHHS which would result in reductions in the amount of savings required of \$27.3 million in 2012-13, \$33.1 million in 2013-14, and \$30 million in 2014-15. There was also an additional \$4 million in 2012-13 for endoscopy and elective surgery procedures.²

The government has never been prepared to say how much of this money, apart from the \$4 million, would go to restore elective surgery capacity that had been lost through the previous cuts. A Legislative Council committee was prevented by the government from securing this information. The matter is further complicated by a failure by the hospitals to achieve the savings targets set for them, and by the constantly increasing demand for services which would have meant, even if all the money had been restored, an increasing gap between the supply of procedures and the demand for them, and a further blowout in waiting lists.

1 *List of savings strategies, DHHS*, 4 October 2011 (reviewed February 2012), DHHS, pp. 3-4.

2 Legislative Council Government Administration Committee 'A', *Inquiry into the cost reduction strategies of the Department of Health and Human Services: Interim Report*, Parliament of Tasmania 2012, p. 27.

The injection of Commonwealth money through the *National Partnership Agreement on Improving Public Hospital Services*³ and, much more significantly, the \$31.2 million over four years allocated to elective surgery under the federal \$325 million ‘rescue package’, represent a major cost-shift from the Tasmanian government to the Commonwealth.⁴ But the Wilkie-Plibersek money will not be enough to reverse the state government’s cuts. The federal ‘rescue package’ allocates \$8.8 million in 2012-13 and \$8.3 million in 2013-14, a total of \$17.1 million over the two years. This would be enough, at Tasmanian prices, to treat about 1,500 patients.

3 *National partnership agreement on improving public hospital services*, COAG, July 2011.

4 *National partnership agreement on improving health services in Tasmania*, COAG, 30 September 2012.

WHAT THE FIGURES SHOW

UNDER THE *National Partnership Agreement on Improving Public Hospital Services*, the states are required to make a range of timely statistical information available to the Commonwealth and the public. The first of these reports, compiled by the Australian Institute of Health and Welfare, provides broad data not only on the state of elective surgery around the country and how each jurisdiction compares, but also shows what has happened in Tasmania in 2012, the first full year after the cuts came into force.⁵ The picture is complicated because Tasmania's performance in elective surgery was already the worst in the nation; the reductions in service capacity and a continuing rise in demand have made it considerably worse.

The figures show that the sacrifice has not been evenly shared. Waiting times have been relatively stable among more urgent cases (such as coronary artery bypass and ear operations) but have blown out massively for some less urgent procedures (such as hip and knee replacements, gall bladder removals, haemorrhoid operations and cataract extractions).

Table 2: Admissions from waiting lists by indicator procedure for elective surgery, waiting times (days) at 50th percentile (median average) and 90th percentile, and change in median wait times over period, Tasmania, 2010-11 to 2012.

Procedure	2010-11			2011-12			2012		Change 2010-11 to 12	
	Admissions	50 th %	90 th %	Admissions	50 th %	90 th %	Admissions	50 th %	Admissions	50 th %
Cataract extraction	1 021	246	435	804	244	551	1 038	309	+1.7%	+25.6%
Cholecystectomy	564	68	454	584	89	521	545	84	-3.4%	+23.5%
Coronary artery bypass graft	201	28	86	187	21	72	160	26	-20.4%	-7.2%
Cystoscopy	789	28	112	675	27	132	632	30	-20.0%	+7.2%
Haemorrhoidectomy	45	33	366	63	52	781	54	76	+20.0%	+130.0%
Hysterectomy	296	48	210	283	53	200	287	65	-3.0%	+35.4%
Inguinal herniorrhaphy	477	54	587	516	58	516	492	67	+3.2%	+24.0%
Myringoplasty	23	180	694	34	130	702	35	62	+52.0%	-66.0%
Myringotomy	122	119	197	173	91	194	153	55	+25.4%	-54.0%
Prostatectomy	53	82	191	42	46	97	43	61	-19.0%	-25.5%
Septoplasty	69	231	721	109	200	601	84	190	-21.7%	-17.7%
Tonsillectomy	335	120	302	356	103	336	276	88	-17.6%	-26.6%
Total hip replacement	277	194	635	189	229	669	193	259	-30.4%	+33.5%
Total knee replacement	300	377	717	201	476	833	203	546	-32.4%	+44.8%
Varicose vein stripping & ligation	36	85	421	26	66	667	24	40	-33.3%	-53.0%
Other procedures	11 889	29	272	11 560	30	264	10 807	29	-9.1%	-
Total Tasmania	16 497	38	359	15 802	38	348	15 026	38	-8.9%	-
Total Australia	620783	36	252	661 707	36	251	670 773	n.p.	n.p.	n.p.

Source: AIHW. For definitions of procedures, see glossary. n.p.: not published.

The 15 indicator procedures were selected because of their high volume. As such, they are often associated with long waits. Any change in performance for these procedures therefore gives a useful picture of the capacity of a hospital system to meet demand. The skewing of services toward urgent and emergency cases, and away from those which can be delayed, has persisted for decades but the process was greatly accelerated by the budget cuts.

Using earlier AIHW data, the following table shows how long Tasmanian elective surgery patients had to wait for treatment in 2011-12, when the effect of the budget cuts was being only partially

⁵ AIHW, *Australian hospital statistics: National emergency access and elective surgery targets 2012*, 28 February 2013.

felt. It shows the median average and 90th percentile wait times for each indicator procedure. The median shows that, of people being actually admitted for their operations, half had waited for less than the median (50th percentile) figure and half had waited for longer; and the 90th percentile figure shows that 90% had waited for less than that time, and 10% for longer.

The data also show the number of people still waiting for their operations a year after being placed on the list, and how Tasmania compares with the rest of Australia. As these figures indicate, Tasmania's performance is poor by Australian standards and, in fact, is the worst in the nation by a considerable margin.

Table 3: Admissions from waiting lists by indicator procedure for elective surgery, waiting times (days) at 50th (median average) and 90th percentile; and percentage still waiting after 365 days, Tasmania and Australia, 2011-12.

<i>Procedure</i>	<i>Median wait</i>		<i>Wait at 90th percentile</i>		<i>Wait more than 365 days</i>	
	<i>Tas</i>	<i>Aust</i>	<i>Tas</i>	<i>Aust</i>	<i>Tas</i>	<i>Aust</i>
Cataract extraction	244	91	551	344	35.2%	4.0%
Cholecystectomy	89	51	521	176	18.0%	2.0%
Coronary artery bypass graft	21	16	72	176	0.0%	<0.1%
Cystoscopy	27	25	132	108	2.6%	1.0%
Haemorrhoidectomy	52	57	781	245	25.4%	3.2%
Hysterectomy	53	53	200	207	1.4%	1.8%
Inguinal herniorrhaphy	58	57	516	277	14.9%	3.1%
Myringoplasty	130	106	702	364	23.5%	9.5%
Myringotomy	91	49	194	145	0.0%	1.1%
Prostatectomy	46	42	97	160	0.0%	1.7%
Septoplasty	200	160	601	370	22.9%	11.8%
Tonsillectomy	103	97	336	358	5.1%	7.2%
Total hip replacement	229	116	669	357	30.7%	7.2%
Total knee replacement	476	184	833	371	52.2%	11.6%
Varicose vein stripping & ligation	66	103	667	365	23.1%	10.0%
Other procedures	30	28	264	181	6.7%	2.1%
Total	38	36	348	251	9.4%	2.7%

Source: AIHW. For definitions of procedures, see glossary.

The exceptionally poor performance of the Tasmanian hospital system in treating the elective surgery patients who rely on it can be seen in the most recent AIHW data, for calendar 2012. These data were compiled to demonstrate how well the Commonwealth government's policy on improving elective surgery waiting times had worked. The results were disappointing in all jurisdictions but nowhere were they as bad as in Tasmania.

The latest AIHW figures also compare elective surgery performance between calendar 2010 and 2012, as well as against the National Elective Surgery Target. Tasmania was given by far the lowest target in most categories but failed to meet any of them. For the number of category-three (lowest urgency) patients still waiting after a year, the state's public hospitals not only failed to reach the target but produced a result that was substantially worse than its own 2010 baseline.

The following two tables show performance by public hospitals in all jurisdictions in the three urgency categories: category one, in which it is clinically recommended that all patients should be treated or referred within 30 days; category 2, in 90 days; and category 3, in 365 days. There are some differences between states in defining these categories, so comparisons, particularly when figures are fairly close together, should be treated with caution. In Tasmania's case, though, the performance is generally so far below its interstate peers that it is implausible that these definition differences would alter the overall picture.

Table 4: Elective surgery performance, 2010 and 2012: proportion seen on time (%)

	Category 1 (30 days)			Category 2 (90 days)			Category 3 (365 days)		
	2010	Target	2012	2010	Target	2012	2010	Target	2012
NSW	92.3	96.0	95.1	86.6	90.0	91.0	89.4	92.0	92.2
Vic	100.0	100.0	100.0	72.5	75.0	68.3	91.9	93.0	90.3
Qld	83.0	89.0	89.0	74.8	81.0	77.1	88.1	91.0	88.7
WA	87.4	94.0	86.3	79.2	84.0	82.0	97.2	98.0	96.4
SA	87.5	94.0	91.0	87.6	91.0	90.7	95.5	97.0	96.3
Tas	*75.4	84.0	*76.1	59.3	67.0	60.4	*76.8	81.0	*72.8
ACT	91.8	95.0	98.5	*44.1	55.0	*57.3	76.9	82.0	89.3
NT	79.1	83.0	87.5	56.9	59.0	71.3	81.6	84.0	86.0

Source: AIHW * denotes poorest national performance

Table 5: Elective surgery performance, 2010 and 2012: average overdue wait (days)

	Category 1 (30 days)			Category 2 (90 days)			Category 3 (365 days)		
	2010	Target	2012	2010	Target	2012	2010	Target	2012
NSW	0.0	0.0	11.0	39.0	29.0	23.6	130.0	98.0	63.4
Vic	0.0	0.0	0.0	129.0	97.0	96.4	165.0	124.0	144.4
Qld	18.0	0.0	*87.5	89.0	67.0	137.1	81.0	61.0	135.8
WA	27.0	0.0	12.1	90.0	68.0	54.2	87.0	65.0	66.9
SA	31.0	0.0	22.7	30.0	23.0	38.2	45.0	34.0	65.8
Tas	*138.0	69.0	72.9	*356.0	285.0	*287.1	*440.0	352.0	*586.4
ACT	45.0	23.0	20.3	179.0	143.0	127.1	246.0	197.0	109.0
NT	67.0	34.0	23.8	97.0	78.0	82.6	144.0	115.0	70.8

Source: AIHW * denotes poorest national performance.

The tables above show who *has* been admitted but do not provide an accurate picture of those who have not, and who may have been on waiting lists for a very long time. The following table shows what happened to the patients who, at the end of 2011, had been waiting the longest for care. It shows that almost all of the 10% longest-wait category 3 patients were still waiting a year later. Again, although some differences between jurisdictions in how urgency categories are calculated prevents this from being a precise measure, the differences between Tasmania's performance and the others are so stark that comparisons between this state and other jurisdictions are reasonable.

Table 6: Number and percentage of the 10% longest-wait overdue patients at the end of 2011 remaining on elective surgery waiting lists at the end of 2012.

	Category 1			Category 2			Category 3		
	End 2011	End 2012	% remain	End 2011	End 2012	% remain	End 2011	End 2012	% remain
NSW	2	0	0%	14	0	0%	26	0	0%
Vic	0	0	0%	641	0	0%	184	0	0%
Qld	37	1	2.7%	422	65	15.4%	107	12	11.2%
WA	15	0	0%	120	0	0%	37	0	0%
SA	6	0	0%	14	0	0%	13	0	0%
Tas	17	0	0%	252	57	22.6%	105	98	93.3%
ACT	2	0	0%	109	0	0%	20	0	0%
NT	4	0	0%	23	2	8.7%	10	1	10.0%

Source: AIHW

There are many reasons why people drop off of waiting lists, apart from being admitted for treatment. These include people who have given up and lost contact, paid for their own treatment in a private hospital, moved interstate or died waiting. It is therefore entirely possible that none of the

2011's longest-wait category 3 patients who remained on the list at the end of 2012 had actually been treated. The figures do not show precise data for the second longest-wait decile but give no reason to believe they have a substantially greater chance of being operated upon.

As we have seen, the main effect of both the basic inadequacy of the system, and the increased inadequacy forced by budget cuts, is not evenly spread. For obvious clinical reasons, the interests of the most seriously ill patients have been preferentially protected, leaving the bulk of the sacrifice to be borne by those who, though often in constant pain, are not at risk of death. Some of these 'elective' patients may never receive their operations.

But the sacrifice is also geographically concentrated. For elective surgery, Tasmania has a three-tier system. At the top are those who can afford to have their operations in a private hospital, attended by a private surgeon. The second tier are those who live in the north-west of the state, where – because of the Commonwealth's funding of the Mersey Hospital – public facilities are fairly readily available. And then there is everyone else. People living in Hobart and Launceston are at the bottom of the heap.

This geographical class-distinction is seen in many categories but can be illustrated by hospital-specific data on waiting times obtained by the Legislative Council's inquiry into the health cuts.

Table 7: Median wait times (days) for patients ready for care, 31 May 2012.⁶

	<i>Category 1</i>	<i>Category 2</i>	<i>Category 3</i>	<i>Total</i>
Royal Hobart Hospital	28	223	350	232
Launceston General Hospital	16	226	248	226
North West Regional Hospital	17	66	119	88
Mersey Hospital	14	36	149	95

Source: DHHS

The same pattern is seen in the times people have to wait for their first consultation with a specialist – the 'waiting list to get on the waiting list'. The national data only tracks people who have had at least one consultation with a surgeon. New state government data indicate that, at the end of 2012, almost 11,000 people were waiting for their first appointment. The Royal Hobart Hospital accounted for some two-thirds.

Table 8: Numbers of patients waiting for first elective surgery specialist consultation Tasmania, 12 December 2012.⁷

RHH	LGH	NWRH/Mersey	Total
7 685	2 292	980	10 957

Source: DHHS

The following table breaks down the results of the waiting lists for the first consultation in each hospital's specialist clinics by urgency category, as well as showing the median waiting time in each. Unfortunately, these recently released data do not divulge any meaningful information about patients who have been waiting the longest. If that information was available, we would be able to determine more about how many can expect never to be treated.

⁶ Legislative Council Government Administration Committee 'A', *Inquiry into the cost reduction strategies of the Department of Health and Human Services: Interim Report, Appendix F*, Parliament of Tasmania, 2012.

⁷ Matthew Daly, *Correction of the record: Data released in response to RTI 1201112-035*, (Letter to Mr Jeremy Rockliff), DHHS, 27 February 2013.

Table 9: Surgery outpatient clinics: patients waiting and median wait (days), 12 December 2012.

<i>Specialty</i>	<i>Category 1</i>		<i>Category 2</i>		<i>Category 3</i>		<i>Total</i>	
	<i>Count</i>	<i>Med. wait</i>	<i>Count</i>	<i>Med. wait</i>	<i>Count</i>	<i>Med. wait</i>	<i>Count</i>	<i>Med. wait</i>
Royal Hobart								
Colorectal surgery	49	113	84	222	70	500	203	268
Dermatology	28	35	212	135	99	196	339	131
Ear, nose & throat	1	139	16	71	1	75	18	71
General surgery	68	64	414	210	396	253	878	229
Gynaecology	1	44	107	40	143	50	251	40
Neurosurgery	529	188	723	523	77	631	1 329	397
Ophthalmology	8	15	261	51	335	756	604	366
Oral-maxillo facial	0	n.a.	0	n.a.	8	47	8	47
Orthopaedic surgery	78	9	35	55	1 071	288	1 184	257
Head & neck surgery	794	265	1 005	443	69	307	1 868	342
Paediatric surgery	0	n.a.	0	n.a.	2	290	2	290
Plastic/reconstructive	89	41	449	194	258	387	796	225
Urology	12	16	86	37	57	56	155	41
Vascular/endovascular	3	22	5	33	42	35	50	33
Total RHH	1 660	190	3 397	267	2 628	300	7 685	258
Launceston General								
Cardiothoracic surgery	0	n.a.	1	61	0	n.a.	1	61
Colorectal surgery	16	19	84	138	126	243	226	170
Dermatology	8	22	71	399	54	576	133	435
Ear, note & throat	21	91	120	149	427	314	568	261
General surgery	30	48	293	205	108	355	431	205
Gynaecology	8	52	147	69	306	144	461	119
Neurosurgery	0	0	1	65	0	n.a.	1	65
Ophthalmology	1	20	n.a.	0	0	n.a.	1	20
Plastic/reconstructive	64	8	54	57	68	243	186	65
Urology	22	26	94	126	142	152	258	134
Vascular/endovascular	22	29	4	82	0	0	26	33
Total LGH	192	27	869	147	1 231	205	2 292	161
NWRH Burnie								
Dermatology	8	164	31	138	22	111	61	137
General surgery	18	47	22	14	1	16	41	16
Gynaecology	2	71	0	n.a.	0	n.a.	2	71
Neurosurgery	0	n.a.	2	968	0	n.a.	2	968
Orthopaedic surgery	10	57	39	61	127	83	176	72
Total NWRH Burnie	38	48	94	69	150	84	282	72
Mersey Community								
General surgery	28	9	66	76	12	60	106	40
Gynaecology	13	27	88	90	69	76	170	86
Orthopaedic surgery	17	8	62	68	174	140	253	104
Urology	5	9	32	113	80	237	117	147
Vascular/endovascular	0	0	8	2	30	112	38	88
Total Mersey	63	9	256	84	365	133	684	96
North-west region*								
General surgery	1	106	0	n.a.	0	n.a.	1	106
Gynaecology	0	n.a.	1	42	0	n.a.	1	42
Ophthalmology	0	n.a.	0	n.a.	11	159	11	159
Orthopaedic surgery	0	n.a.	0	n.a.	1	30	1	30
Total NW region	1	106	1	42	12	159	14	159
Total Tasmania	1 954	147	4 617	202	4 386	233	10 957	204

Source: DHHS. *This refers to clinics which may have been held at either the NWRH or the MCH.

The crucial category is category 3, the least-urgent. These patients are most readily bumped to the

bottom of the queue and often kept there in the face of competition from more urgent elective and emergency cases. The figures demonstrate the inability of the Royal Hobart Hospital, particularly, to deal adequately with the patients who rely upon it. The median wait times for neurosurgery (397 days) and ophthalmology (366 days) are of serious concern.

At none of the hospitals are these figures satisfactory but at the RHH, the median wait times in all three categories are plainly unacceptable and clinically dangerous. The chances of patients' conditions deteriorating markedly, and of the development of severe and occasionally life-threatening complications, as a result of waiting times is clear and serious.

POLICY IMPLICATIONS

THE DISMAYING state of Tasmania's elective surgery performance was worsened but not created by the state government's budget cuts. Rather, these made an unacceptable situation even less acceptable. There are no valid excuses: Tasmania has a somewhat poorer, sicker and older population than the rest of the country but there are countervailing factors in our favour. These population characteristics are balanced by an increase in the state's share of GST. Our distances are small, our travel times short and our population relatively centralised. It can take just as long to drive from one side of Sydney to the other as to get from Hobart to Launceston. Indigenous Tasmanians do not have the level and complexity of health problems of aboriginal and islander people in northern Australia or in western New South Wales and western Queensland. The state of our economy and the state government's capacity to raise money are, again, recognised and offset by GST redistribution policies.

No jurisdiction provides adequate access to elective surgery for its people but the reason Tasmania is so far behind all the others is that our hospitals are by far the least economically efficient in the nation. That, in turn, is the result of government policies that have failed for decades and have been allowed to go on failing.

The problems are seen across the system in the extraordinarily high costs revealed by two separate data-gathering processes. The AIHW calculated that the average cost per casemix-weighted separation – that is, the cost of the average service allowing for complexity – was, for acute inpatients, 20.2% higher than the national average in 2010-11.⁸ The Commonwealth government's National Hospital Cost Data Collection for 2009-10 estimated the average cost per weighted separation at 26% higher than the nation as a whole.⁹

The sudden and unpredictable imposition of budget cuts in 2011 meant hospitals were unable to ameliorate the effects of the cuts on patients by fundamentally improving the efficiency of their systems – even if they had been willing to do which, given a long-standing resistance to reform in many areas of our public hospitals, is doubtful. Some genuine efficiency improvements have been made but other changes forced by the sudden cuts are likely to have the opposite effect.

The Tasmanian government does not have in place, and does not appear to be contemplating, reform of the scope and significance which could substantially eliminate the present enormous waste and to use that money to treat patients who, at present, have no prospect of ever being treated.

⁸ AIHW, *Australian Hospital Statistics 2010-11*, Canberra 2012.

⁹ National Hospital Cost Data Collection, Round 14 (2009-2010), Department of Health & Ageing, Canberra (quoted in Alan Bansenmer et al, *Interim Report*, Commission on Delivery of Health Services in Tasmania, Canberra, December 2012.

GLOSSARY

Case mix A system of assigning a cost to particular hospital services, on the basis of what that service ought to cost. Also known as activity-based funding.

Cholecystectomy Surgical removal of the gall bladder, usually as a result of frequent gallstones.

Cystoscopy Examination of the bladder with an instrument inserted through the urethra.

Haemorrhoidectomy Surgical removal of haemorrhoids (piles).

Inguinal herniorrhaphy Surgical repair of a hernia (rupture) in the lower abdomen.

Myringoplasty Surgical repair of a perforated eardrum.

Myringotomy Incision of the eardrum to allow infected fluid to escape.

Prostatectomy Surgical removal of the prostate gland.

Septoplasty Surgical correction of a deviated septum, the partition between the two nasal cavities, the large air-filled spaces above and behind the nose.