The health of Health

2016

A report on the state of Tasmania's public hospital system in the first two years of the Hodgman government

Martyn Goddard
Independent health policy analyst
December 2016

Executive summary

For many years, the Tasmanian public hospital system has lagged behind other states, usually finishing last, in its capacity to meet the needs of its population. The failure of the system to meet community requirements and expectations was one of the principal reasons for the resounding defeat of the Labor-Green government in 2014; it was also a leading cause of the Liberal Party's disastrous performance in this year's federal election.

A question worth examining, then, is whether Tasmanian politicians – and specifically, those leading the present state government – have learnt the lesson of these two elections. In coming to office, the Hodgman government described the hospital system as 'broken' and promised to fix it.

There have been some advances under the present government in organisational reform, clinical redesign and elective surgery. Broadly, though, the evidence presented in this report reveals that the promise to fix a broken system has been resoundingly broken. The chances of a Tasmanian patient receiving the care he or she needs are now lower than they have ever been.

State government funding

Data from the Australian Institute of Health and Welfare show that for at least the last decade, Tasmanian state government *per* capita funding for public hospitals has been far lower than in almost any other state or territory.[1] Great damage was done by the Labor-Green government's budget cuts of 2011. In the final years of that government some of that damage was rectified but the downward trend resumed under the new Liberal government. Overall, the funding situation facing Tasmania's public hospitals is now worse than it has ever been and, according to budget figures, is about to deteriorate sharply over the next few years.

The state government in 2014-15 spent $335, or 6.7 per cent, less than other states for every man, woman and child resident in Tasmania. This is despite Tasmania having the nation's oldest, sickest and poorest population with a reliance on the public hospital system which is second only to the Northern Territory.

The 2016 state budget reveals that this situation will deteriorate further. In 2016-17, state payments to the Tasmanian Health Service – that is, the covers recurrent funding of public hospitals – will fall in dollar terms by $30,900, or 0.9 per cent. When price inflation and average increases are taken into account, this represents cut in real terms equal to $91.5 million.

By the end of the four-year forward estimates the effective funding shortfall, compared with previous long-term cost trajectories, will be a cumulative $367 million. That is on top of funding levels that are already the lowest in the nation.

[1] **NOTE**: Previously, the Tasmanian government has disputed the AIHW figures, saying they differ from data derived from various state budgets. But there is little requirement for consistency between the budget papers of various governments: they are calculated in different ways, are highly vulnerable to political interference, and cannot validly be compared. They also do not separate payments from state governments from other-source payments such as the Commonwealth, individuals private health insurance, workers' compensation and third party accident insurance. The AIHW data, on the other hand, are designed to be comparable across the nation. All states are required to report detailed financial results and patient-level data according to consistent definitions issued by the AIHW. These are the only figures that accurately show the relative performance of state-based hospital systems.

The role of the GST

In the context of state government funding, it is important to realise that the state already receives money in GST distribution not only to allow it to meet the national *per capita* average in health and hospital funding, but also to cover the additional needs of a population in far greater need than other Australians of public health and hospital services. It is therefore important to have a basic understanding of how GST redistribution works, and how it affects the amount of money available for hospitals.

In determining the share of the GST pool to be allocated to each state or territory, the Commonwealth Grants Commission first ensures that each jurisdiction has enough money to provide the same level of services to its people, regardless of how much money a particular state can raise through its own taxes, charges and enterprises. On that basis, Tasmania has as much money to spend on health, *per capita,* as any other state. Tasmania does very well at this basic stage of redistribution.

But because each state population is different and has its own levels of need, the Commission goes further. It conducts a rigorous review of the specific needs of each population across all major service areas – health, education, justice, transport and so on. On top of the money allocated in the first stage of the process, described in the previous paragraph, Tasmania receives enough money to meet all of the higher-than-average health needs of its population. This year, the health-specific allocation for this state will be $251 million. This would allow the state government to spend well over the national *per capita* average on health – if it wanted to.

But none of this $251 million will be spent on health. If it was, the amount spent by the Tasmanian government on health would be well above the national average. Instead, in 2014-15 it was $172 million *less* than the average. To get the total picture, we must combine the two – the amount we get in extra GST to bring us up to a *per capita* average, and the amount allocated specifically for the higher health needs of Tasmanians. In all our government will this financial year spend at least $423 million less than on health than it receives. This is a conservative figure which does not take into account the further funding cuts in this year's state budget.

Over the past ten years, this underspending by successive governments amounted to $2.174 billion. Of this, $861 million, or 40 per cent, was in the first two years of the Hodgman government.

Bed numbers

The clearest evidence of whether or not a state's people are being short-changed by their government's health funding, relative to other states, is in the number of acute-care beds provided in public hospitals. On the basis of simple population share, Tasmania should have 2.2 per cent of the nation's public hospital beds. In fact, the AIHW figures for 2014-15 show that we would need an additional 82 beds to meet this national average benchmark.

But this does not take into account the much higher-than-average health needs of the Tasmanian population. In its review of the relative health needs of all states and territories, the Commonwealth Grants Commission calculates – and then funds – the needs of all areas of state health and hospital services. Applying the Commission's weightings for admitted care, Tasmania would need a total of an extra 200 beds to be able to deliver inpatient care of a national-average level and quality to its people.

Staffing

Numbers of doctors and nurses were savagely reduced in the two years following the Giddings government's budget cuts. Since then, full-time equivalent (FTE) doctor numbers have further declined and now stand at 181 fewer than in 2010-11. Each FTE doctor is now on on average responsible for 46 more patients in a year than five years ago.

The situation for nurses is more complex. FTE numbers are now higher than they were in 2010-11 and have kept pace with inpatient numbers. But those FTE numbers hide a massive shift from full-time to part-time and casual nurses, a heavy use of expensive agency nurses and a major reliance on overtime. All of these impact on the working conditions and job security of the state's public sector nurses.

The government's policy of restricting public service head-count numbers has hit our hospitals hard and, overall, involves higher costs and even more money diverted from patient care. If three elements resulting from these staff shortages – locum doctors, agency nurses and nurses' overtime – are put together, they accounted in 2014-15 for a largely-avoidable cost of $9.1 million. That money alone would employ an extra 120 full-time nurses at an average level of seniority or an extra 57 specialist doctors.

Caseload

The regular increase in the number of inpatients being treated in our hospitals – measured by 'weighted separations' which adjust for cost and complexity – has slowed dramatically under the present government. A rise of 14.4 per cent over the last two years of the previous government has slowed to 3.5 per cent over the first two years of the present government. This represents the slowest growth for some years. The most likely cause is that hospitals, without substantially increased staff numbers and funding, are less capable than ever of handling the community's demand for care. Doctors and nurses cannot work any harder than they now do. The gains in efficiency as a result of increased labour unit output have come to an end.

Tasmanians are also use public hospitals less than their interstate peers. The number of patient days (one patient in hospital for a day equals one patient day) is by far the lowest in the nation, and 13.6 per cent below the national average.

The number of inpatients treated in a year is also the lowest, 15 per cent less than the nation as a whole.

This is despite the needs of an older, sicker, poorer population which ought to be able to access much more hospital care than other Australians. The need is there but our hospitals cannot meet it.

Emergency

Similarly, fewer Tasmanians present to emergency departments than is the case elsewhere in Australia. But the time they have to wait for care are far longer than the national average and on a part with the equal worst, Western Australia. There has been a collapse in the number of people seen by a doctor within the clinically recommended time, from 72 per cent before the present government came to office, to 66 per cent in the twelve months to June this year. The number of emergency presentations in 2015-16 was 296 per 1,000 population in Tasmania and 311 nationally. This is a long-term trend and cannot be sheeted home only to the present government.

The most likely explanation for this relative under-use of emergency is that potential patients expect

treatment times to be long. The public is well aware of the pressures and difficulties that occur in the emergency departments of our two major hospital at times of peak demand.

The greatest cause of the inability of emergency department staff to be able to cope with even this reduced demand is bed block – the high number of people needing to be admitted to the hospital, but for whom no bed on a ward is available. At the 90th percentile – which means 10 per cent of patients have waited this length of time or longer – the time spent in emergency in 2015-16 was 19 hours 24 minutes, against 10 hours 43 minutes nationally. These people are those most affected by bed-block. They are high-need, sick people who demand a massive share of staff attention. While doctors and nurses are looking after these people, they cannot deal with new patients coming through the door.

Bed block is dangerous. Research has shown that people affected by bed block are 30 per cent more likely to die than those for whom a bed is available. The evidence shows that there are more deaths from bed block in Tasmania than there are from road accidents.

Elective surgery

The proportion of Tasmanians being admitted for elective surgery has risen under the present government from one of the lowest in the nation to the highest. This is due to the government's 'blitz' on patients who have been waiting the longest. This initiative has largely been funded with $20 million over two years which was left over from a one-off injection of $325 million into the Tasmanian health system by the Gillard federal government. Of this, $12 million was paid last year and $8 million will be paid this year. When the money runs out at the end of June 2017, we can expect Tasmania to return to its place at the bottom of Australia's elective surgery rankings.

Even with this initiative, the proportion of elective surgery patients seen within the clinically recommended time is grossly below the performance of other states. Nationally, well over 90 per cent of are treated on time. In Tasmania, the figure in 2015-16 was 59.3 per cent.

Measures of safety and quality, though – unplanned readmissions and adverse events – are among the best in Australia.

Elective surgery waiting times are massively extended by the time it takes for someone to be put on the official waiting list. For that to happen, they have to have their first consultation with a surgeon – a process which (in the case of neurosurgery) can take over five years.

Reform

There have been two broad streams of reform during the first two years of the Hodgman government:

- The *One State, One Health System* process initiated by the state Minister for Health; and
- The process of clinical redesign, initiated and funded by the Gillard government.

The state-initiated administrative changes, consisting of replacing three hospital networks with one and changing the roles of the three hospitals in the north and north-west, are likely to improve coordination, efficiency and the quality of care. They are unlikely to add greatly to the overall capacity to meet patient demand. The plan to turn the Mersey Hospital into a state-wide centre for elective surgery is hampered by the lack of funding; and even with adequate funding it is unlikely to serve substantial numbers of people from the south of the state. A separate elective surgery centre is urgently needed in Hobart but the government has no plans to provide one. Nevertheless, these are

necessary and overdue reforms.

The Commonwealth-funded program of clinical redesign, run by a unit attached to the University of Tasmania, has achieved significant efficiencies, including measures that have effectively released 25 to 30 more acute beds for use. It has also achieved some improvement in outpatient and emergency care. But all of these advances, though laudable and useful, are dwarfed by the massive shortfalls in funding and resources.

Broadly, despite these reforms and some positive outcomes, Tasmania's position at the bottom of Australia's performance ladder has substantially worsened during the Hodgman government's first two years.

State government funding

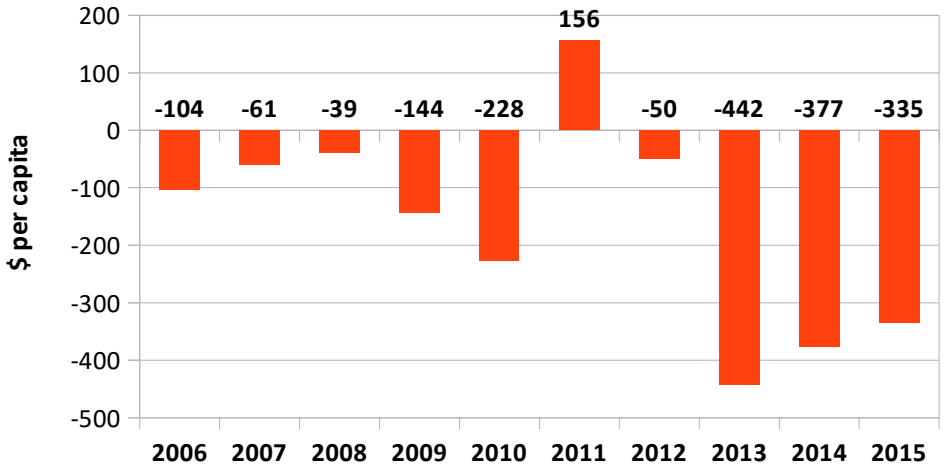
For at least the last decade, Tasmanian state government *per capita* funding for public hospitals has been far lower than in almost any other state or territory. With the Labor-Green government's budget cuts in 2011, *per capita* hospital funding dropped sharply, from $1,646 to $1,275 in a single year. It has never recovered.

Table 1: State/local government health expenditure, total and per capita, current prices, 2005-06 to 2014-15

	NSW		Vic		Qld		WA		SA		Tas		ACT		NT	
	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)
2005-06	7 396	1 101	4 913	978	4 046	1 021	2 240	1 103	1 822	1 179	476	975	538	1 611	477	2 304
2006-07	7 853	1 157	5 342	1 046	5 019	1 237	2 627	1 265	1 992	1 276	554	1 126	572	1 692	526	2 493
2007-08	8 132	1 181	5 383	1 035	5 819	1 399	2 946	1 380	2 310	1 464	603	1 216	614	1 785	573	2 641
2008-09	8 349	1 192	5 683	1 070	6 602	1 544	3 289	1 489	2 586	1 618	608	1 211	716	2 040	659	2 955
2009-10	9 029	1 271	6 421	1 185	7 812	1 789	3 533	1 561	2 931	1 810	649	1 283	834	2 330	663	2 908
2010-11	9 455	1 317	6 957	1 266	8 102	1 826	4 239	1 828	3 033	1 858	872	1 710	933	2 556	856	3 722
2011-12	10 148	1 397	7 228	1 295	9 221	2 040	5 297	2 214	3 373	2 048	844	1 648	1 066	2 873	1 046	4 489
2012-13	11 243	1 528	7 250	1 276	9 387	2 037	5 350	2 157	3 301	1 986	653	1 275	1 078	2 852	1 089	4 456
2013-14	11 678	1 565	8 143	1 408	9 480	2 023	5 502	2 165	3 617	2 157	714	1 389	1 013	2 645	984	4 049
2014-15	12 034	1 590	8 430	1 431	9 573	2 016	5 536	2 152	3 499	2 069	743	1 442	1 067	2 751	1 086	4 470

Source: AIHW, Australian Health Expenditure

Chart 1: Total Tasmanian state government health funding, variation from national average ($ per capita), years ending June 2006 to 2015



These trends were evident long before the present state government came to power. The 2011 budget cuts by the Labor-Green government hit public hospitals particularly hard. This showed up not only in the funding figures but also in the loss of doctors and nurses, the further overcrowding of wards, the decline in elective surgery performance and the incapacity of emergency departments to cope with peak periods.

Table 2: Per capita state/local government health expenditure and national state/territory average, current prices, 2005-06 to 2014-15

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
2005-06	1 101	978	1 021	1 103	1 179	**975**	1 611	2 304	**1 079**
2006-07	1 157	1 046	1 237	1 265	1 276	**1 126**	1 692	2 493	**1 187**
2007-08	1 181	1 035	1 399	1 380	1 464	**1 216**	1 785	2 641	**1 255**
2008-09	1 192	1 070	1 544	1 489	1 618	**1 211**	2 040	2 955	**1 355**
2009-10	1 271	1 185	1 789	1 561	1 810	**1 283**	2 330	2 908	**1 511**
2010-11	1 317	1 266	1 826	1 828	1 858	**1 710**	2 556	3 722	**1 554**
2011-12	1 397	1 295	2 040	2 214	2 048	**1 648**	2 873	4 489	**1 698**
2012-13	1 528	1 276	2 037	2 157	1 986	**1 275**	2 852	4 456	**1 717**
2013-14	1 565	1 408	2 023	2 165	2 157	**1 389**	2 645	4 049	**1 766**
2014-15	1 590	1 431	2 016	2 152	2 069	**1 442**	2 751	4 470	**1 777**

Source: AIHW, Health Expenditure Australia

Given that the Giddings government's performance in health was a leading issue before and during the 2014 election campaign, it is highly probable that many of the people who voted in the Hodgman government so convincingly believed the party's pre-election promise to 'fix Labor's mess in health'. Frequently after being elected the new Health Minister, Michael Ferguson, described the system as 'broken' and, once again, vowed to fix it.

In fact, those promises have been resoundingly broken. Not only has the damage cause by Labor's cuts not been repaired; the situation has worsened in almost every area, with Tasmania falling further and further behind the rest of the nation. The clearest evidence for this is in the financial figures.

The 2016 Tasmanian budget papers show much greater funding pressures than in the past on public hospitals. Over the forward estimates, payments for recurrent expenditure by the Tasmanian Health Service, which is responsible for all public hospitals, 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 3).

Table 3: State budget payments to the Tasmanian Health Service, recurrent expenditure ($000), 2015-16 and 2016-17

2016-17 budget	Change YOY	2016-17 budget	Change YOY
1 386 536	**+30 900 (+0.9%)**	**1 368 081**	**-18 455 (-1.3%)**

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

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. 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 4, these figures show the full effect of that situation over the forward estimates period.

Table 4: State budget forward estimate payments to the Tasmanian Health Service, recurrent expenditure, ($000), 2015-16 to 2019-20

	2015-16	*2016-17*	*Change*	*2017-18*	*Change*	*2018-19*	*Change*	*2019-20*	*Change*
Admitted services	760 331	772 698	+1.6%	765 352	-1.0%	762 657	-0.4%	793 870	+4.1%
Non-admitted services	154 239	167 534	+8.6%	172 481	+3.0%	173 109	+0.4%	177 324	+2.4%
Emergency departments	122 114	115 194	-5.7%	115 073	-0.1%	116 715	+1.4%	119 447	+2.3%
Community & aged care	200 907	194 407	-3.2%	189 461	-2.5%	188 987	-0.3%	191 327	+1.2%
Statewide & mental health	116 803	116 813	0.0%	118 472	+1.4%	121 378	+2.5%	123 410	+1.7%
Forensic medicine	1 242	1 435	+15.5%	1 477	+2.9%	1 654	+12.0%	1 698	+2.7%
Total	**1 355 636**	**1 368 081**	**+0.9%**	**1 362 316**	**-0.4%**	**1 364 500**	**+0.2%**	**1 407 076**	**+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.

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 5: 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 costs will increase by 34%.[4]

[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. This comprises long-term averages of price inflation and increasing demand as measured by the Australian Institute of Health and Welfare.

Table 6: 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%***

This is not, despite a popular belief, because Tasmania – as a poor state – cannot afford to spend any more on health. No one who understands Australia's GST redistribution arrangements would accept that easy excuse.

The role of the GST

The process of distributing the pool of money raised by the Goods and Services Tax – called horizontal fiscal equalisation – is designed to allow each state and territory to deliver an equal level and quality of service to its people. To achieve this, the Commonwealth Grants Commission takes into account the particular circumstances of each jurisdiction, including how much money it can raise itself and the specific needs of its population.

If this system was not in place, rich states like New South Wales and Victoria would be able to afford first-class services and people in poorer states like Tasmania and South Australia would have hospitals and schools barely above third-world standards. Redistribution of money within a federation, where states or provinces do not control their own currencies, is a basic requirement of any successful federation. Without it, the federal system of government would become almost impossible.

In making this process work, the Grants Commission proceeds in two broad stages:

- The first is to calculate how much a state is capable of raising through its own efforts, given an equal level of 'taxation severity'. It then redistributes money so that each jurisdiction has about the same *per capita* revenue.
- The second is to look at the specific needs of each state's population – distances, income and wealth, age, health status, educational needs and so on. This involves a broad and exceptionally rigorous assessment of relative needs to allow distribution of the money in the GST pool to be accurately and fairly calculated.

In both of these areas, Tasmania does exceptionally well: the state government's relative inability to raise its own revenue, the lack of a large minerals industry and the low average income of its people, all attract major compensation. The Commission also recognises that the state's relatively low-income population relies more heavily on public facilities, particularly in health and education. In 2015-16, the total GST allocation for Tasmania was $2.299 billion, representing 65.2% of state budget revenue.[5]

It is misleading for the Treasurer to say, in interviews and in the budget papers, that the state will lose $84 million from this year's GST revenue (and $500 million over the forward estimates) as a result of revised GST shares.[6] Because of the decline in mining revenue for states like Western Australia and Queensland, GST shares have moved somewhat towards the mining states to make up for their decreased income from royalties. This year, Tasmania's share of the pool was 3.8% against 3.9% last year. But, as the Commission noted, the overall pool was substantially bigger than last year and Tasmania's share – far from decreasing by $84 million – in fact rose by $50 million, or $90 per head, from $2.249 billion to $2.299 billion. That is an actual rise of 2.2%.

Because of the rebound in commodity prices, particularly iron ore and coal, it is highly probable that Tasmania's share will increase over the current forward estimates period as allocations move away again from the royalty-rich mining states. And because Australia's economic output continues to grow, GST revenue generally will increase to Tasmania's disproportionate benefit.

The Treasurer, Mr Gutwein, has used the misleading claim about GST losses to justify taking hundreds of millions of GST money away from public hospitals to pursue a budget surplus at a time

---

5 *Budget Paper 1, 2016-17*, Department of the Treasury, Tasmania.

6 *Tasmania set to lose 'around $84 million' in latest GST carve-up*, Treasurer says, ABC news online, 8 April 2016.

when the costs of borrowing to fund any deficit are at record lows.[7]

In its calculations of the relative needs of each state for health funding, the Grants Commission examines a wide range of factors including the determinants of population health such as income, education, age and disease burden; the presence of private hospitals; the population's financial capacity to access private options; and so on. It is a remarkably rigorous examination.

This financial year, this process delivered to the Tasmanian government an extra $251 million, redistributed from other states, because of the specific health needs of this state's population. None of that money was spent on health.

Table 7: Health impact of GST distribution, total and per capita, 2004-05 to 2016-17

	NSW		*Vic*		*Qld*		*WA*		*SA*		*Tas*		*ACT*		*NT*		*Redist*
	Total	**P/cap**	**Total**	**P/cap**	**Total**	**P/cap**	**Total**	**P/cap**	**Total**	**P/cap**	**Total**	**P/cap**	**Total**	**P/cap**	**Total**	**P/cap**	**Total**
	($m)	*($)*	*($m)*	*($)*	*($m)*	*($)*	*($m)*	*($)*	*($m)*	*($)*	*($m)*	*($)*	*($m)*	*($)*	*($m)*	*($)*	*($m)*
2004-05	-101	-15	-271	-55	28	7	48	24	98	64	**40**	**82**	-65	-198	222	1 088	437
2005-06	-63	-9	-301	-60	38	10	30	15	103	67	**39**	**80**	-70	-210	224	1 082	434
2006-07	-60	-9	-345	-68	55	14	34	16	92	59	**36**	**73**	-67	-198	255	1 209	472
2007-08	-68	-10	-395	-76	84	20	25	12	115	73	**41**	**83**	-75	-218	273	1 258	537
2008-09	18	3	-388	-73	15	4	29	13	75	47	**43**	**86**	-75	-214	283	1 269	463
2009-10	37	5	-382	-70	-18	-4	25	11	86	53	**25**	**49**	-69	-193	296	1 298	469
2010-11	-312	-43	-460	-84	-66	-15	278	120	123	75	**106**	**208**	-29	-79	360	1 565	867
2011-12	-519	-71	-667	-119	-15	-3	480	201	145	88	**133**	**260**	-31	-84	473	2 030	1 231
2012-13	-697	-95	-640	-113	106	23	504	203	136	82	**154**	**301**	-13	-34	448	1 874	1 349
2013-14	-655	-88	-701	-121	32	7	592	233	136	81	**172**	**335**	1	3	424	1 745	1 356
2014-15	-658	-86	-816	-138	-2	<1	699	271	109	64	**170**	**330**	-10	-26	509	2 086	1 487
2015-16	-531	-69	-987	-164	70	14	557	206	173	102	**266**	**515**	-68	-170	518	2 049	1 586
2016-17	-499	-65	-972	-162	74	15	543	201	163	96	**251**	**486**	-70	-174	507	2004	1 638

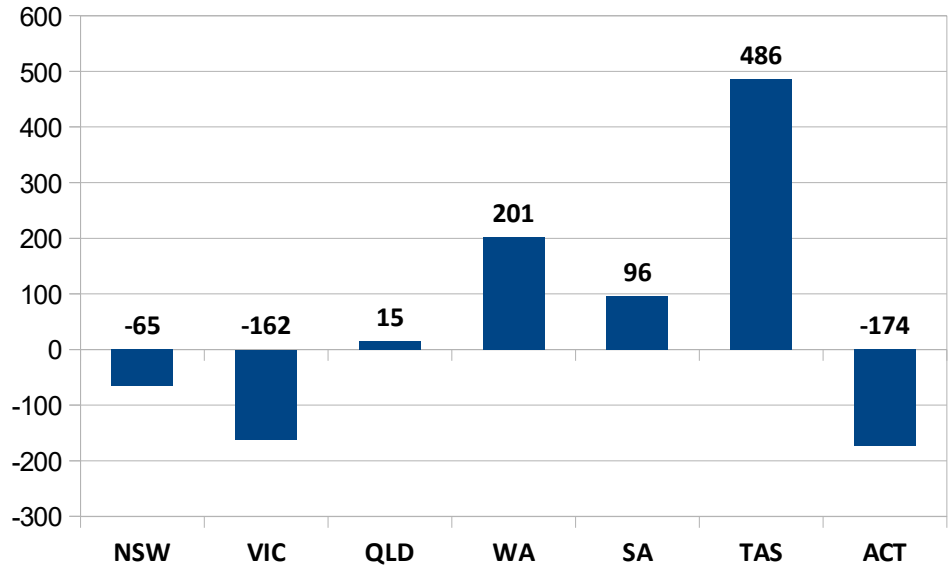
Source: Commonwealth Grants Commission

If that money was being spent on health, it would show up in the national figures: the Tasmanian government's per capita health expenditure would be the second-highest in the nation. But, as we have seen, the opposite is the case: successive Tasmanian governments have consistently spent less per person on health than the governments of any other state or territory.

The total impact of this under-funding on Tasmania's health system is best measured by first calculating the difference between the state's per capita health spending and the national average,and then multiplying that figure by population to achieve a total state-wide figure. Adding this to health-specific GST grants gives us a total outcome showing a relative underspend in every year of the period.

[7] Peter Gutwein, *Revised GST forecasts show need for continued budget discipline*, Tasmanian government, 8 April 2016.

Chart 2: Redistribution of GST for health services, per capita, states and territories, 2016-17



The total impact of this under-funding on Tasmania's health system is best measured by first calculating the difference between the state's per capita health spending and the national average, and then multiplying that figure by population to achieve a total state-wide figure. Adding this to health-specific GST grants gives us a total outcome showing a relative underspend in every year of the period.

It should be noted that the generosity of GST health funding for Tasmania has increased markedly over the period. Once every five years, the Grants Commission conducts a complete review of its methods; in the 2004 Review, it recognised the need for specific attention to differing health needs across the country. Tasmania benefited significantly. In its 2010 Review, the Commission calculated that far more redistribution was needed. Tasmania benefited still more, with its health-specific GST allocation jumping from $25 million in 2009-10 to $106 million in 2010-11. In its 2015 Review the state's treatment was even more generous, jumping from $170 million in 2014-15 to $251 million in 2016-17. Despite what the state government claims, this is a solid funding stream. It can be relied upon. The excuse that it is too volatile to be put into health funding is not valid.

Table 8: Health under-spending by the Tasmanian government ($'000), recurrent and capital, years ending June 2006 to 2016

	2007	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*Total*
+/- av [(a)]	-30 012	-19 344	-72 288	-115 368	+79 560	-25 600	-226 304	-193 778	-172 010	*-172 010**	-947 154
GST [(b)]	-36 000	-41 000	-43 000	-25 000	-106 000	-133 000	-154 000	-172 000	-266 000	-251 000	-1 227 000
Outcome [(c)]	-66 012	-60 344	-115 288	-140 368	-26 440	-158 600	-380 304	-365 778	-438 010	-423 010	-2 174 154

(a) The amount by which the Tasmanian government's contribution to total health funding varies from the national average (population adjusted).

(b) The amount of health-specific GST funding received by Tasmania.

(c) The total amount that funding from state government sources (including GST receipts) varies from the national average (population adjusted).

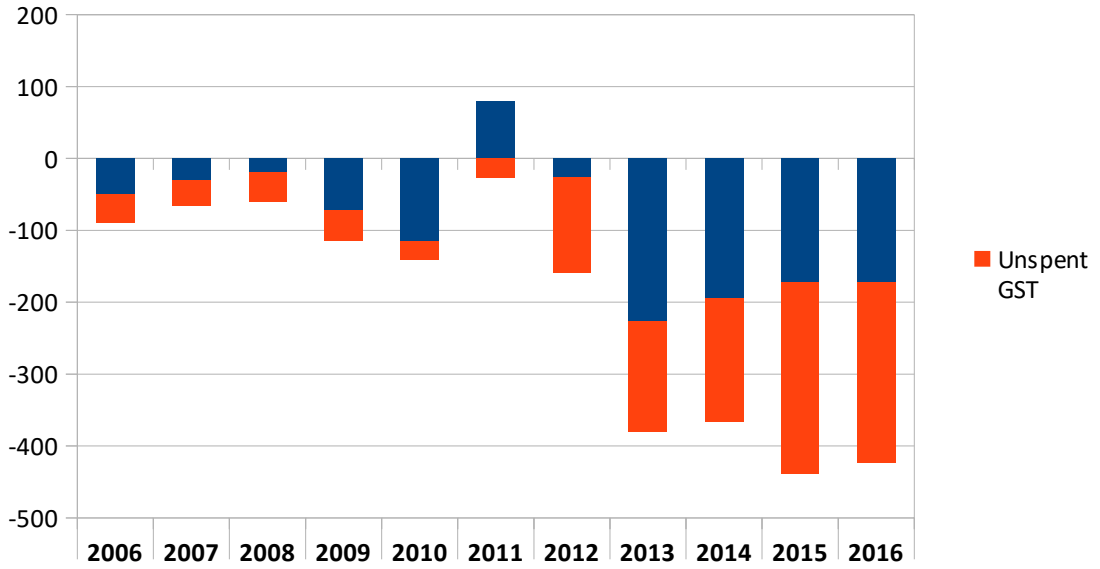
**Assuming the underspend in 2015-16 was no greater than in the previous year.*

Sources: Australian Institute of Health & Welfare, Commonwealth Grants Commission, ABS population estimates

Both Table 8 and Chart 3 show the components of state government health funding – its own direct contribution and the annual amount of health-specific GST – in comparison with the national average on a population-adjusted basis.[8]

Over the decade to 2015-16, Tasmanian governments have underspent on health, compared with their interstate peers, by $2.174 billion. Of this, $861 million has been in the first two years of the Hodgman Liberal government. The combined effect of the rise in health-specific GST allocations and state budget cuts means the performance of the present government is far worse even than its predecessor.

Chart 3: Health under-spending ($ million) by the Tasmanian government, recurrent and capital, population adjusted, years ending June 2006 to 2016



From the point of view of patient care, total-spending figures, such as those used so far in this paper, can be misleading. Totals include not only recurrent spending – the amount used to keep the system going from day to day – but also capital, the money used for buildings and equipment. Capital is almost always 'lumpy': the cost of a new building will accrue to the years in which it is built but may be used for half a century or more. It is therefore useful to isolate recurrent spending, to see how the system is maintained in the long term. In Tasmania's case, that makes the picture even more dispiriting. It shows that the single year in which Tasmanian per capita health spending exceeded the national average, in 2010-11, was solely due to one-off capital items.

[8] **NOTE**: Previously, the Tasmanian government has disputed the AIHW figures, saying they differ from data derived from various state budgets. But there is little requirement for consistency between the budget papers of various governments: they are calculated in different ways, are highly vulnerable to political interference, and cannot validly be compared. They also do not separate payments from state governments from other-source payments such as the Commonwealth, individuals private health insurance, workers' compensation and third party accident insurance. The AIHW data, on the other hand, are designed to be comparable across the nation. All states are required to report detailed financial results and patient-level data according to consistent definitions issued by the AIHW. These are the only figures that accurately show the relative performance of state-based hospital systems.

Bed numbers

The clearest evidence of whether or not a state's people are being short-changed by their government's health funding, relative to other states, is in the number of acute-care beds provided in public hospitals. The simplest way of looking at this is to see whether a particular state has more or fewer beds per capita than the country as a whole. We can see from Table 9 that Victoria, Queensland, Western Australia, and Tasmania have fewer beds per capita and that New South Wales, South Australia and the two territories have more.

Table 9: Actual acute public hospital bed numbers by state and territory and numbers needed for equal allocation by population share, 2014-15

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT**	*NT*	*Aust*
Bed numbers	19 860	13 754	11 426	5 463	4 770	**1 198**	1 068	664	58 203
Population share (%)	32.0	25.1	20.1	10.9	7.1	**2.2**	1.6	1.0	100
Variance from average	+1 235	-855	-273	-881	+638	**-82**	+137	+82	58 203

** The ACT's per-capita share is, and needs to be, higher than the average because it treats people from a wide area of NSW. Interestingly, the NSW share is also higher.*

Sources: AIHW, Australian Hospital Statistics (Hospital Resources 2014-15); ABS Australian Demographic Statistics.

This is, though, a somewhat crude way of looking at the situation. The populations of different states have different needs for public funded health care: Tasmania has the nation's oldest, poorest and sickest population and therefore a greater need for public hospitals than any other jurisdiction other than the Northern Territory. As we have seen already, this is recognised by the Commonwealth Grants Commission which conducts rigorous examinations of differing needs across all areas of health – admitted patient care, emergency, transport, ambulance, outpatients, prevention and so on. It calculates a relative weighting for each jurisdiction to reflect their differing needs in all these categories.

To reach a systematic view of the extent to which states and territories deliver the number of acute beds to provide a level of care at the national average standard, given differing population needs, we must take the number of beds demanded by crude population share, and then adjust that number according to the Commission's admitted-care weightings. We can then see, for each state, the number of beds needed – whether more or fewer – to reach the national average level care. According to this method, more beds are needed in New South Wales, Western Australia, Tasmania and the Northern Territory. Victoria, Queensland, South Australia and the Australian Capital Territory[9] have more beds than the average.

Table 10: Acute bed numbers required to deliver an equal level of services, 2014-15

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Bed needed for pop share[1]	18 625	14 609	11 699	6 377	4 132	**1 281**	931	582
CGC weighting[2]	1.009	0.972	0.990	0.998	1.038	**1.091**	0.907	1.292
Beds by CGC weighting[3]	18 792	14 200	11 582	6 331	4 289	**1 398**	844	752
Extra/fewer needed[4]	1 068+	446-	156-	868+	481-	**200+**	224-	88+

1: Number of beds in each state if total national bed numbers were distributed according to population shares.

2: Commonwealth Grants Commission weighting for admitted patients.

3: Number of beds each state would have if population share and CGC weightings were both applied.

4: Number of beds needed to achieve (3).

Sources: AIHW, Australian Hospital Statistics; Commonwealth Grants Commission; ABS Demographic Statistics

[9] Although a significant element of ACT caseload comprises people living in southern NSW, the Grants Commission weightings take this into account.

Staffing and caseload

By the time of the Labor-Green government's savage budget cuts to health in 2011, Tasmania was already behind the rest of the nation in the provision of adequate public hospital services to its people. Those cuts dramatically worsened the situation and have never been adequately reversed either by that government or by its successor. Today, Tasmania indisputably has by far the worst record in health care in the nation.

As we have seen, this has its basis in continued budgetary restriction but shows up almost anywhere clinical staff are working and patients are being treated.

Table 11 shows the steep decline in doctor and nurse numbers – particularly doctors – in the two years following the 2011 cuts. But the present government, despite promising to fix the 'broken' system, has signally failed to do so. Doctor numbers declined further after the new government came to power and, after two years in office, the number was still 181 below the 2011 level and even below the number it inherited from Labor.

The nursing situation looks somewhat better, though most of the repair work had been done under the previous government. In its first two years in office, the Liberal government added only 95 full-time equivalent nurses to the state's public hospital system.

Table 11: Full-time equivalent medical officers and nurses, Tasmania June 2014 to March 2016

	2011	*2012*	*2013*	*2014*	*2015*	*2016*	*5-year change*
Salaried doctors	977	857	771	804	*763	796	
Change		*-120*	*-86*	*+33*	**-41*	*+33*	*-181*
Visiting doctors	n.a.	n.a.	n.a.	40	41	41	
Change					*+1*	*0*	*n.a.*
Nurses	2 801	2 736	2 634	3 253	3 289	3 348	
Change		*-65*	*-102*	*+619*	*+36*	*+59*	*+547*

**The 2015 decline was partly due to a reclassification of locums rather than an overall reduction in clinician numbers in the north-west.*

Source: Hansard, House of Assembly, 11 June 2015 and 6 June 2016; AIHW Australian Hospital Statistics.

A 'separation' is defined as a completed episode of inpatient care. A single patient with more than one condition can sometimes account for more than one separation, but in general terms, one patient equals one separation. But not every separation involves the same level of cost, complexity and staff attention. The raw numbers are therefore also weighted according to nationally accepted formulae. These figures emphasise the extent to which service delivery has suffered during the first two years of Liberal government. After growing very strongly for many years, the number of weighted separations has now slowed almost to a halt.

Table 12: Weighted separations, four major hospitals, 12 months to June 2013 to 2016, showing numbers, difference from previous year, and percentage difference

RHH				*LGH*				*NWRH*				*Mersey*				*4-hospital total*			
2013	**2014**	**2015***	**2016**	**2013**	**2014**	**2015***	**2016**	**2013**	**2014**	**2015***	**2016**	**2013**	**2014**	**2015***	**2016**	**2013**	**2014**	**2015***	**2016**
56762	59729	60348	60500	32827	36614	38432	41052	11755	14092	13624	14038	8040	9368	8723	8430	109384	119803	121127	124020
+3048	+2967	+619	+152	+402	+3787	+1818	+2620	+782	+2337	-468	+414	+1014	+1328	-645	-293	+5246	+10419	+1324	+2893
+5.7%	+5.2%	+1.0%	+0.25%	+1.2%	+11.5%	+5.0%	+6.8%	+7.1%	+20.0%	-3.3%	+3.0%	+14.4%	+16.5%	-6.9%	-3.4%	+5.0%	+9.5%	+1.1%	+2.4%

** For the 2015 calendar year.*

Source: DHHS.

The performance of the Liberal government in its first two years, compared with that of Labor in its last two, is seen most clearly in Table 13. In all three regions, growth in the number of patients being treated has collapsed; in the state's major referral hospital, the Royal Hobart, there has been growth of only 1.3% over the past two years, compared with 11.2% in the last two years of the Labor government. At the Launceston General, the growth rate is now a quarter of what it was; in the north-west, demand has shifted dramatically away from the Mersey, most probably in line with the government's administrative reorganisation. In the two hospitals serving the north-west – in Burnie and Latrobe – growth in admitted patient care fell from 31.6% in the last two years of Labor to 2.7% in the first two years of the Liberals.

Table 13: Weighted separations, major public hospitals, Tasmania, 2012-13 and 2015-16

	RHH			*LGH*			*NWRH*			*Mersey*		
	2011-12	**2013-14**	**2015-16**	**2011-12**	**2013-14**	**2015-16**	**2011-12**	**2013-14**	**2015-16**	**2011-12**	**2013-14**	**2015-16**
Number	53 714	59 729	60 503	32 425	36 614	37 768	7 741	10 678	14 002	8 870	11 174	8 430
Change		6 015	774		4 189	1 154		2 937	3 324		2 304	-7 256
% change		**11.2%**	**1.3%**		**12.9%**	**3.2%**		**37.9%**	**31.1%**		**26.0%**	**-24.6%**

Source: DHHS Progress Chart, September 2014; DHHS Dashboard (accessed October 2016).

Not surprisingly, Tasmania has been falling further behind the rest of the nation in the capacity of its hospitals to deliver core inpatient care. Although the AIHW does not give comparative figures for weighted separations, the raw separation numbers tell the story. Even though this state has Australia's oldest, poorest and sickest population – and therefore is the most reliant on adequate public hospital services – the chances of a Tasmanian getting into a hospital are the worst of any state or territory. This is despite, as we have seen, the large amount of money flowing to the Tasmanian government from other states to pay for services that exist in other states but not here.

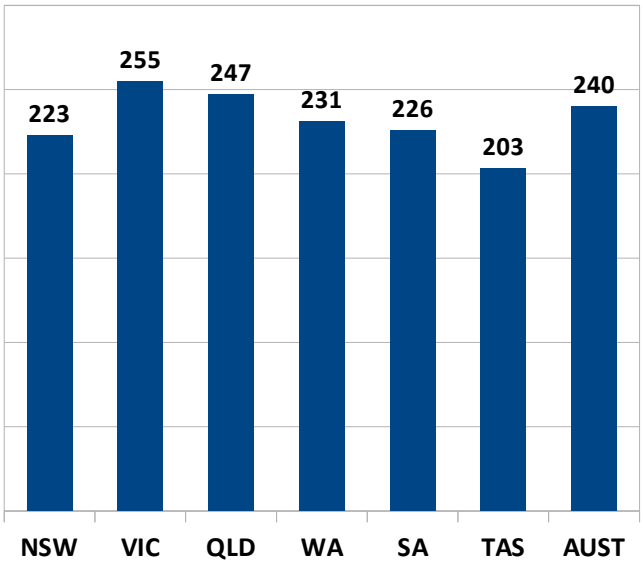
Table 14 shows inpatient numbers, adjusted for population, are the lowest in the country – and 15 per cent lower than the national average. Tasmania has almost certainly fallen even further behind the rest of the nation since these figures were compiled.

Table 14: Raw separations per 1,000 population, states and territories, 2014-15

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Average*
Overnight	121.1	107.9	115.0	106.4	119.0	**100.1**	124.1	189.7	**115.1**
Same-day	101.5	147.0	131.7	124.6	106.6	**108.2**	143.1	408.3	**125.1**
TOTAL	222.6	254.9	246.7	231.0	225.6	**203.3**	267.2	598.0	**240.2**

Source: AIHW, Admitted patient care 2014-15

Chart 4: Separations per 1,000 population, states, 2014-15



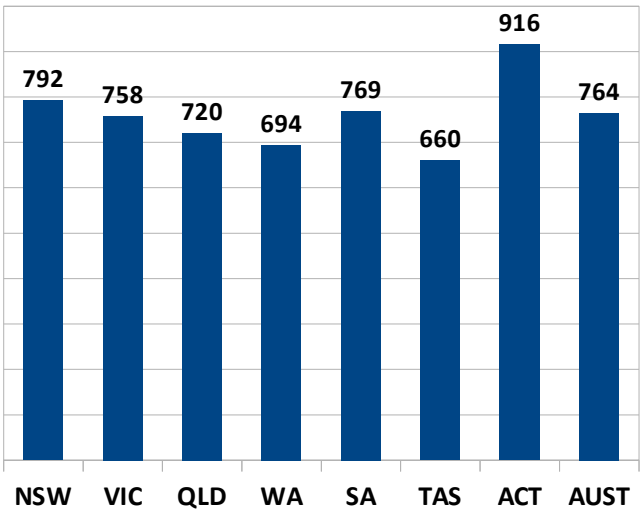
Patient days (one patient admitted for one day equals one patient day) also show how Tasmanians find it harder than other Australians to access needed hospital care. In 2014-15 the number of patient days this state's hospitals were able to provide was 13.6 per cent less than the national average.

Table 15: Patient days per 1,000 population, public hospitals, states and territories, 2014-15

NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Average*
792.2	758.2	719.9	693.6	768.8	**659.8**	915.8	1 615.0	**763.5**

Source: AIHW, Admitted patient care 2014-15

Chart 5: Patient days per 1,000 population, public hospitals, states, 2014-15



With funding, staffing and in some cases physical capacity barely growing – and in fact shrinking

rapidly when long-term cost trends are considered – doctors and nurses have come to the end of their capacity to treat ever more patients. As Table 16 shows, Over the last four years, under both governments, nurse numbers have barely kept pace with growth. What the figures do not show is the increasing workload of individual nurses, in the absence of enough doctors and with support staff, such as ward clerks, being sacked under the present government's economy drive.

The most worrying aspect of staffing is the explosion in the number of patients each doctor is expected to treat. Over the past six years, the number of inpatients for every hospital doctor has risen from 110 to 156, or 42 per cent. Nurse workload, as measured by this statistic, has remained level.

Table 16: Changes in workload: Weighted separations per FTE doctor and nurse, four major hospitals, years ending 2010, 2012, 2014 and 2016

Separations per	*2010*	*2012*	*Change 2010-12*	*2014*	*Change 2012-14*	*2016*	*Change 2014-16*
Doctor	110	121	+11	149	+28	156	+7
Nurse	38	38	-	37	-1	37	-

Source: DHHS

Table 16 gives a credible explanation of the escalation in doctors' workload, though the situation is complicated by their work outside of inpatient wards, overtime, lack of support staff and so on. Most of these factors support the conclusion that the 42 per cent figure above is an understatement.

For nurses, the table provides a much less reliable indication of workload. The full-time equivalent number is being maintained despite a shortage of full-time salaried staff and a consequent reliance on overtime, agency nurses and casuals.

Table 17: Full-time equivalent nursing staff, Tasmanian public hospitals, 2013 to 2016

		2013[(a)]	*2014[(a)]*	*2015[(a)]*	*2016[(b)]*
Permanent	**Full time**	976.87	969.93	900.04	891.83
	Part time	1 750.38	1 834.41	1 854.33	1 917.77
	Total	***2 727.25***	***2 804.34***	***2 754.37***	***2 809.60***
Fixed term	**Full time**	106.13	67.23	59.84	60.49
	Part time	256.44	285.90	338.98	356.28
	Total	***362.57***	***353.12***	***398.82***	***416.77***
Casual		187.77	217.59	222.53	229.86
TOTAL		***3 277.59***	***3 375.05***	***3 375.72***	***3 456.23***

(a) At June.
(b) At March 2016.
Source: DHHS RTI 1201516-099

Between 2013 and 2016, the number of FTE positions filled by nurses who are employed full-time fell from 977 to 892, a reduction of 85; while the number of part-timers and casuals rose from 2,194 to 2,504, an increase of 310.

This does not show the number of FTE positions filled by people working overtime of those filled by expensive agency nurses. The cost of those is seen in Table 18.

Table 18: Total amount spent ($) in each financial year on agency nurses by region, 2012-13 to 2015-16

Financial year	*North*	*South*	*North-west*	*TOTAL*
2012-13	340 367	100 465	925 067	***1 365 899***
2013-14	614 796	110 205	843 088	***1 568 089***
2014-15	507 196	67 459	1 295 681	***1 870 336***
2015-16	538 949	56 586	897 058	***1 492 593***

Source: DHHS RTI 1201617-037

But there are many other problems in the nursing area that create greater concern – the reliance on casual and part-time staff, overtime levels, working conditions, the ability to retain existing staff and to recruit new ones.

Of more concern is overtime. It is evident from the figures that a significant part of the FTE nursing staff numbers is achieved not by employing enough full-time nurses but by demanding (and paying) substantial amounts of overtime. This is consistent with the government's policy of restricting public service numbers, which is intended to contain costs. In this case, the policy does the opposite:

Table 19: Nurse overtime costs, by major hospital and region, Tasmania 2015-16

	Hours	*Cost ($)*
Royal Hobart Hospital	35 022	2 357 992
Rest of southern region	13 368	1 096 294
TOTAL SOUTH	**48 390**	**3 454 286**
Launceston General Hospital	49 517	2 601 500
Rest of northern region	5 622	372 960
TOTAL NORTH	**55 139**	**2 974 460**
North-West Regional Hospital	8 803	546 511
Mersey Community Hospital	5 308	273 772
Rest of north-west region	2 998	359 348
TOTAL NORTH-WEST	**17 109**	**1 179 631**
TOTAL FOR STATE	***120 638***	***7 608 377***

Source: DHHS: RTI1201617-053

The total cost of overtime and agency nurses in 2015-16 was $9,100,970.

The cost of locum doctors is also of concern. Locums are expensive: typically, a locum specialist will be paid $2,000 a day ($2,500 for emergency specialists), plus a house, return air fares for themselves and their families, and a car.

Table 20: Cost ($) of locum doctors by region, 2012-13 to March 2016

Financial year	*South*	*North*	*North-west*	*TOTAL*
2012-13	231 290	668 243	11 355 569	***12 255 102***
2013-14	426 949	863 640	13 695 548	***14 986 137***
2014-15	516 402	797 719	13 430 917	***14 745 038***
***2015-16**	1 328 616	3 012 650	12 216 939	***16 558 205***

** 12 months to 31 March.*
Source: DHHS RTI 1201516-110

In 2015-16, the cost of locums was almost ten per cent of the amount spent on salaries of medical

practitioners. In the north-west, where the reliance on locums is extraordinarily high, their costs was 48 per cent as much as the amount spent on salaried doctors.

Table 21: Cost ($) of salaried medical practitioners, Tasmania by region, 2013-14 to 2015-16*

	2013-14	*2014-15*	*2015-16**
South	94 959 231	100 167 757	99 505 557
North	45 793 263	48 376 135	47 064 300
North-west	31 241 902	28 190 867	20 908 699
TOTAL	***171 994 397***	***176 734 760***	***167 478 557***

Costs for salaried medical practitioners do not include locum costs. Figures do include employer superannuation on-costs.
**Financial year to date to 21 May 2016.*

In 2015-16 the cost of three items resulting from not employing enough full-time salaried clinical staff – locum doctors, nurses' overtime and agency nurses – amounted to $25,659,175. That would employ an extra 120 full-time nurses at an average level of seniority or an extra

Emergency

Throughout Australia, emergency departments are under immense stress. If scandals of poor care are to happen, they often happen here – not because of the quality of the staff but because of the pressures of the task. Despite a downturn coinciding with the 2011 budget cuts, presentations have continue to grow, although less quickly than for the nation as a whole. In the four years since that time, Tasmanian emergency presentations grew at an average of 2.3 per cent a year, against a national average of 3.2 per cent.

Table 22: Emergency department presentations, Tasmania, 2011-12 to 2015-16

	2011-12	*2012-13*	*2013-14*	*2014-15*	*2015-16*
Number	141 700	147 064	148 278	150 076	153 541
Change (%)*	-1.5%	3.8%	0.8%	1.2%	2.3%

** Change from previous year.*
Sources: AIHW

Contrary to popular belief, the difficulty of accessing other forms of health care – such as GPs – does not appear to be forcing disproportionate numbers of Tasmanians into emergency departments. Table 18 shows that although the population-adjusted rate has increased steadily, Tasmanians use public hospital emergency departments significantly less than other Australians. This is a consistent trend.

Table 23: Emergency department presentations per 1000 population, Tasmania and Australia, 2011-12 to 2015-16

	2011-12	*2012-13*	*2013-14*	*2014-15*	*2015-16*
Tasmania	277	287	288	291	296
Australia	291	293	309	312	311

Source: AIHW, ABS

Despite relatively low numbers of people presenting at emergency departments, the times they have to wait for treatment are far longer than the national average and on a par with the equal worst, Western Australia. There has been a collapse in the number of people seen within the clinically recommended time under the present government – from 72 per cent before it came to office, to 66 per cent in the twelve months to June this year.

Table 24: Emergency waiting time statistics, Tasmania and Australia, 2011-12 to 2015-16

	2011-12	*2012-13*	*2013-14*	*2014-15*	*2015-16*
Median wait, Tas (min)	24	24	23	25	27
Medial wait, Aust (min)	21	19	18	18	19
Seen on time, Tas (%)	71	71	72	70	66
Seen on time, Aust (%)	72	73	75	74	74

Source: AIHW

The effect of bed block – patients needing admission to the hospital being kept in emergency because there are no vacant beds on a ward – can be seen in the median length of stay data. For patients who can be treated within emergency, Tasmania's length of stay is comparable with the rest

of the country. But people needing to be admitted must remain in emergency, often for long periods, until a bed can be found for them. As these patients may be seriously ill, this adds substantially to staff workload and in their ability to deal with newly presenting patients. Even more seriously, two separate Australian studies have found an increase in mortality risk of 30 per cent if patients are admitted through overcrowded emergency departments to overcrowded hospitals.[10,11] This is particularly serious if the cause of the delay is a lack of intensive care beds, as is often the case in Tasmania's major hospitals.

Table 25: Emergency department median lengths of stay (hours: minutes) states and territories, 2015-16

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
Patients admitted	4:37	3:56	3:50	3:58	4:28	**5:59**	6:17	**2:06**
Patients not admitted	2:01	2:25	2:17	2:10	2:30	**2:14**	2:12	**2:13**
All presentations	2:33	2:56	2:47	3:00	2:36	**3:00**	2:59	**2:44**

Data for the ACT were not reported.
Source: AIHW

Tasmania's problem with bed block is seen even more clearly when comparisons are made between this state and the rest of the country. Although the situation has shown some marginal improvement, Tasmania's performance contrasts starkly with that of the rest of the country, where median emergency stay for patients needing to be admitted has fallen dramatically over the past five years.

Table 26: Median length of emergency department stay (hours: minutes) Tasmania and Australia, 2011-12 to 2015-16

		2011-12	*2012-13*	*2013-14*	*2014-15*	*2015-16*
Admitted	**Tasmania**	6:10	6:13	6:02	6:05	5:59
	Australia	5:49	5:15	4:27	4:16	4:06
Not admitted	**Tasmania**	2:10	2:11	2:08	2:15	2:14
	Australia	2:17	2:19	2:07	2:08	2:13
All presentations	**Tasmania**	2:42	2:41	2:41	2:49	2:50
	Australia	2:58	2:53	2:40	2:41	2:44

Source: AIHW

The impact of bed block is seen even more clearly among patients at the 90th percentile of length of stay (Table 27). This means that 10 per cent of patients have waited this long or longer. The situation for these people – those most likely to be affected by bed block – shows their waiting times are almost double the national average. Again, as the national situation has shown major improvement, in Tasmania there has been none.

Table 27: Emergency department presentations, 90th percentile of emergency stay, presentations ending in admission (hours: minutes), Tasmania and Australia, 2011-12 to 2015-16

	2011-12	*2012-13*	*2013-14*	*2014-15*	*2015-16*
Tasmania	16:53	20:47	19:33	21:34	19:24
Australia	14:23	13:41	11:49	11:41	10:43

Source: AIHW

[10] Chalfin DB, Tzereciak J-A, Likourezos A, et al: DELAY-ED study group. Impact of delayed transfer of critically ill patients from the emergency department to the intensive care unit. *Critical Care Medicine;* 2007; 35: 1477-1483.

[11] Spirivulis PC, Da Silva J-A, Jacobs IG, The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments. *Medical Journal of Australia* 2006; 184: 208-212.

There has recently been controversy about the number of people who present at emergency departments and who leave before seeing a doctor, or who leave prematurely after seeing a doctor. Both of these can be an indicator of long waiting times and inadequate emergency care for lower-risk patients. Overall, though, Tasmania has the lowest rate in the country.

Table 28: Number and proportion of patients presenting to emergency departments who did not wait or who left at their own risk, states and territories, 2015-16

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
Did not wait (n)	82 940	82 949	46 204	21 662	17 799	5 708	10 305	267 567
Left at own risk (n)	60 111	23 603	30 579	6 821	3 865	582	1 348	126 909
TOTAL (n)	143 051	106 552	76 783	28 483	21 664	6 290	11 653	394 476
Did not wait (%)	3.0%	5.0%	3.2%	2.6%	3.7%	3.7%	6.9%	3.6%
Left at own risk (%)	2.2%	1.4%	2.1%	0.8%	0.8%	0.4%	0.9%	1.7%
TOTAL (%)	5.2%	6.3%	5.3%	3.4%	4.5%	4.1%	7.8%	5.3%

Data for the ACT was unavailable.

Source: AIHW, Elective surgery waiting times 2015-16

Elective surgery

Elective surgery is the single major area of the Tasmanian public hospital system which has improved in the past year. This is largely due to the government's blitz on patients who have been waiting the longest. The number of admissions rose from 15,598 in 2014-15 to 18,973 in 2015-16, an increase of 21.6 per cent. When adjusted for population, the rate of elective admissions rose over the year from the fourth in the nation to the top.

Table 29: Admissions per 1,000 population from elective surgery waiting lists, states and territories, 2011-12 to 2015-16

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2011-12	28.8	27.6	25.3	34.4	39.6	30.9	30.6	31.2	29.3
2012-13	29.1	27.0	26.0	34.3	38.6	30.2	30.8	32.6	29.3
2013-14	29.0	29.4	27.2	34.3	37.6	29.8	30.7	31.3	30.0
2014-15	28.8	29.4	26.6	32.2	36.9	30.3	30.6	31.4	29.5
2015-16	28.4	29.8	29.4	33.5	35.1	36.7	n.a.	32.9	29.7

Source: AIHW, Elective surgery waiting times 2015-16

This temporary surgery blitz is the most recent of many. This approach to policy has been used many times before, throughout Australia, to address high-profile and politically embarrassing problems in elective surgery. Nationally, there was a similar blitz by the newly elected Rudd government in 2008 with 'up to' $600 million promised to the states for 'slashing elective surgery waiting lists'.[12] For a time, as with all these temporary measures, figures improved. But when the money ran out, the situation became worse than ever.

The Tasmania's government's measure is based largely on diverting an unspent $20 million from a package of $325 million negotiated in 2012 between the Denison independent Andrew Wilkie and the health minister in the Gillard government, Tanya Plibersek. According to this year's federal budget documents, $12 million of this was paid in 2015-16 with the remaining $8 million to be paid this financial year. At the end of June 2017, that money – and the blitz – will end.

The Tasmanian government has also attributed the improvement to a '$76 million investment in elective surgery', a claim that needs to be seen in context.[13] This money was announced some 18 months before the new government was elected and has been re-announced many times since. It was to be spent over the four years, an average of $19 million a year. But this money has been dwarfed by the massive effective budget cuts to the entire health portfolio under the present government. Overall, it could be argued that the package does not exist: far more has been taken away than has been given. This is confirmed by the elective surgery figures between the last year of the Labor government and the first year under the Liberals, before the $20 million in Commonwealth funding became available. There was almost no change in elective admissions between those two years.

Another caveat is in the mix of procedures being undertaken. There is a huge difference in cost and complexity between a cardiac artery bypass graft or a total knee replacement and a cataract extraction or an endoscopy. But in the raw admission figures, all are counted as equal. Therefore, a

[12] Nicola Roxon, *Ending the blame game: reforming the health and hospital system,* media release, Minister for Health, Canberra 13 May 2008.

[13] Michael Ferguson, *Elective surgery improvements,* media release, Minister for Health, Hobart, 30 November 2016.

large number of cheap, simple procedures such as cataract replacements can distort our view of the amount of real work being achieved.

Table 30 shows that the number of extra cataract extractions, compared to the year before, is almost three times the number of extra knee replacements. Even though the number of some more complex procedures has also increased – for instance, knee replacements rose by 55 per cent – the raw overall figures overstate the amount of work actually being done.

Table 30: Admissions from elective surgery waiting lists by selected procedure, Tasmania, 2014-15 and 2015-16

	2014-15	*2016-17*	*Number change*	*% change*
Cataract extraction	1 490	2 119	629	42%
Cholecystectomy[(a)]	513	558	45	9%
Coronary artery bypass	119	119	-	-
Cystoscopy[(b)]	906	1 130	224	25%
Hysterectomy	256	356	100	39%
Inguinal herniorrhaphy[(c)]	401	541	140	35%
Tonsillectomy	359	482	123	34%
Total hip replacement	313	381	68	22%
Total knee replacement	284	439	155	55%

Comparative data prior to 2014-15 are not available.
(a) Removal of gallstones
(b) Endoscopy of urinary bladder
(c) Surgical repair of hernia in males
Source: AIHW, Elective surgery waiting times 2015-16

The Minister for Health is justified in saying that the 2015-16 increase in waiting times for people admitted from the elective surgery waiting list is a product of targeting the longest-wait patients.[14] But even taking this into account, Tasmania's elective surgery waiting times remain by far the longest in the nation. In 2015-16, only 59.3 per cent were admitted within the clinically recommended time, compared figures above 90 per cent in all jurisdictions except the Northern Territory.

Table 31: Proportion of elective surgery patients admitted within the clinically recommended time, Tasmania, 2015-16

	Category 1 (30 days)	*Category 2 (90 days)*	*Category 3 (356 days)*	*Total*
NSW	99.8%	97.1%	95.6%	97.1%
Vic	100.0%	77.1%	93.7%	87.9%
Qld	97.6%	94.7%	98.4%	96.6%
WA	91.8%	89.3%	98.1%	93.5%
SA	90.0%	88.4%	95.3%	91.4%
Tas	77.1%	43.4%	62.9%	59.3%
NT	93.2%	66.9%	80.4%	79.2%

Data for the ACT was unavailable.
Source: AIHW, Elective surgery waiting times 2015-16

Indicators of safety and quality of care in elective surgery compare well with other states. The proportion of patients experiencing an adverse event as a result of their treatment is below the

[14] Ferguson, *ibid.*

national average (Table 32) and the proportion needing an unplanned readmission within 28 days is by far the lowest in the nation, as it has been for at least several years (Table 33).

Table 32: Adverse events reported for admissions from public hospital elective surgery waiting lists, states and territories, April 2015 to March 2016

	NSW	Vic	Qld	WA	SA	Tas	NT	Aust
Number with adverse event	11 269	13 057	9 338	4 870	3 655	998	329	43 699
% with adverse event	5.4%	7.8%	7.4%	5.8%	6.1%	6.0%	4.8%	6.4%

Data for the ACT were unavailable.
Source: AIHW, Elective surgery waiting times 2015-16

Table 33: Unplanned 28-day readmissions following admission from elective surgery waiting lists, states and territories, April 2015 to March 2016

	NSW	Vic	Qld	WA	SA	Tas	NT	Aust
Readmissions	2 282	1 663	2 351	939	827	4	180	8 275
% with a readmission	1.1	1.0	1.9	1.1	1.4	<0.1	2.7	1.2

Data for the ACT were unavailable.
Source: AIHW, Elective surgery waiting times 2015-16

Outpatient clinic waiting times

Waiting times for elective surgery cannot be fully understood without also looking at how long people have to wait to have their names put on the waiting list: something that cannot happen until their first consultation with a specialist. But the waiting times for those initial clinics can be even longer than those on the 'official' elective surgery waiting list. In October 2016, 25 per cent of the most urgent patients needing neurosurgery were having to wait at least 18 months to see a surgeon. For those in the least-urgent category, the figure was five-and-a-half years.

Table 34: Indicative surgical clinic waiting times in days (75th percentile)[(a)] Royal Hobart Hospital, October 2016

Clinic	Urgent	Semi-urgent	Non-urgent
Colorectal	42	160	1 022
Colposcopy [(b)]	39	63	63
Ear, nose and throat	69	1 089	1 520
Ear, nose & throat paediatric	-	666	890
General surgical	41	174	329
Neurosurgery	580	1 555	1 985
Ophthalmology	48	229	281
Orthopaedic	15	421	698
Plastic	50	216	672

(a) 75th percentile means 25% of patients wait for this long or longer. Longest waiting times are not released.
(b) Endoscopy to detect cervical cancer.
Source: DHHS

Reform and efficiency

There have been two principal streams of reform in the Tasmanian public hospital system since the present government came to power:

- The *One State, One Health System* process initiated by the state Minister for Health; and
- The process of clinical redesign, initiated and funded by the Gillard government.

State-based reform

The core of this process has been the transfer of administration from three region-based Tasmanian Health Organisations into a single statewide Tasmanian Health Service. A committee and consultation structure was put into place. Although this measure has probably saved some administrative costs, the main purpose of the reform was to allow services to be better coordinated across the state and to allow the three main hospital in the north and north-west to work more easily together and to share specialist staff and equipment.

These policies were outlined in a White Paper in 2015. Other major reforms were to include:

- Changing the role of the Mersey Community Hospital to improve efficiency and safety. The Mersey previously contained a number of expensive facilities which were grossly under-utilised, including its High Dependency Unit, and which did not have the level of caseload required to maintain staff skills. These were therefore considered unsafe as well as inefficient. The High Dependency Unit was replaced by a short-stay unit for people who need stabilisation before being transferred to a larger centre.
- A number of services were transferred from the Mersey to the NWRH, changing the Mersey's role toward being a provider of sub-acute care, including palliative care, more in line with the capacities of a smaller institution.
- It was announced that the Mersey would become an elective surgery centre for the entire state.
- Arrangements were made for the previously unused radiation oncology centre at the NWRH to be operated by visiting specialists from the LGH.
- There was to be almost no change to the role of the RHH.

Clinical redesign

The ongoing clinical redesign initiative is being run by Health Services Innovation Tasmania, which is attached to the University of Tasmania and funded by the Commonwealth as part of a $325 million initiative of the Gillard government.

Much of that $325 million was wasted by the Commonwealth, including on an unnecessarily elaborate Commission of Inquiry costing many millions but whose report revealed little that was not already known. The redesign process, while costing a fraction of the $325 million, has a significant chance of making substantial long-term improvements to the efficiency of the state's hospitals.

Initiatives have included:

- **Streamlining access to outpatient clinics**. These administrative changes have lowered some of the waiting times but these remain a major problem. Patients are not placed on waiting lists for elective surgery and other services until their first consultation with a specialist. Outpatient clinic waiting lists are often referred to as 'the waiting list to get on the waiting list'. These times remain unacceptable long – up to several years in some cases. Administrative streamlining, though laudable, cannot address the core problems of insufficient staff numbers and funding.
- **Emergency department waiting times**. A number of changes in the Royal Hobart Hospital's emergency department, including the appointment of a red-shirted 'navigator', have increased the proportion of patients seen by a doctor in under four hours from 57 per cent to 68 per cent. But this measure – in the RHH and in the state generally – remains well below the national average. Other statistics show a decline in performance over the same period. Administrative change within emergency has not and cannot adequately address the fundamental problems of inadequate funding, staff and – particularly – of the critical shortage of acute-care beds which prevents patients from being admitted from emergency into the main hospital.
- **Length of stay** for medical inpatients has been reduced at the RHH by 0.85 of a day, equating to having 8.2 more beds available each day. The changes have addressed delays to doctors' rounds, discharge, paperwork and reducing the length of meetings. However, the length of stay for medical inpatients in Tasmania was already below the national average. Under the AIHW's relative length of stay index, any figure below 1 indicates shorter stays than would be expected; anything above 1 indicates longer stays. For Tasmania in 2014-15, medical patients has an index score of 0.97; surgical patients had a score of 1.05.
- **Length of stay** for medical inpatients at the LGH has been reduced by half a day.
- **Efficiency of bed use** has been improved across the major hospitals. This is estimated to have resulted in an effective increase of between 25 and 30 in acute beds for admitted patients. While undoubtedly helpful, this improvement has been dwarfed by the pressure on beds (and bed block). Tasmania would need another 200 beds to bring services to a national average standard.

It is also important to note that most other states have engaged in clinical redesign for much longer than Tasmania. The sort of improvements achieved here are also likely to have been achieved, or surpassed, elsewhere. Therefore, Tasmania's position against the rest of the nation – the main benchmark used in this report – is likely to have remained relatively steady.