

ECONOMIC INEFFICIENCY
IN TASMANIAN
PUBLIC HOSPITALS

MARTYN GODDARD

JANUARY 2013

EXECUTIVE SUMMARY

ACCORDING TO the best available data, Tasmania has the nation's least economically efficient public hospital system. The most fundamental measure of efficiency – what we get for our money – shows Tasmania is behind all states and territories in obtaining value for money in our public hospital system. Data collected by the Australian Institute of Health and Welfare shows that the cost of each 'casemix weighted separation' – that is, comparing like with like across the range of all services – in 2010-11 was \$5913 in Tasmania, \$5645 in the Northern Territory (the next most expensive jurisdiction), \$4908 across the average of the nation and \$4508 in Victoria, the most efficient state. The cost of the average service in Tasmania was 20% higher than the national average and 31% higher than in Victoria.

If Tasmanian hospitals had been as efficient as the national average, \$101.5 million would have been saved in that year and another 20,600 patient services delivered. If Victoria's standard had been reached, \$143 million would have been saved and another 31,000 services delivered.

As with most statistics, these interstate comparisons have a margin of error, mostly from differences in the detail of coding between various hospitals and states. But this is not enough to disturb the overall picture. The unfavourable comparison with the Northern Territory is damning for the administrators of Tasmania's system. The particular and intractable health problems faced in the Territory – its high and decentralised indigenous population, its low overall population and its vast distances – should, one would think, result in a system in which every service costs more. And so it does, but not as much as in Tasmania, which has none of the Territory's special-case needs. Even the ACT, with the notoriously expensive Canberra Hospital, gives better value for money. Tasmania may never quite be able to match the economies of scale achieved in Victoria but there is no excuse at all for its lamentable performance.

It is true that, under the pressure of major state government budget cuts, a number of efficiencies have at last been made; but the other jurisdictions have been improving their performance too. It is unlikely that the next set of figures, when they are published later this year, will greatly alter this depressing league table. The most we can realistically hope for is that we may compare a little better with the Northern Territory.

None of the usual excuses work. The Royal Hobart and Launceston General hospitals, which account for the majority of patients, are not small outfits: they are in the national mid-range. Reasonable economies of scale should be achievable, particularly in purchasing and in the flexible utilisation of staff and facilities. Tasmania's population is older, sicker and poorer than the national average but this does not affect the cost of individual hospital services: a hip replacement or a course of intravenous antibiotic should not vary so much. Staff, individually, are not paid more than in other states. The only reason which stands up to scrutiny is that Tasmania's hospitals are badly run and have been for many years.

Over a third of staff in the three Tasmanian Health Organisations, which are responsible for running groups of hospitals, are paid under the Health and Human services award: in other words, they are public servants. One in five of the staff employed within our hospitals are clerks or administrators. There are almost as many administrators as nurses, and several times as many clerks as doctors. In the Southern THO, the only one for which even limited data of this sort are available, between 2010-11 and 2011-12 the number of clerks and administrators was reduced by 2%, the number of nurses by 8.5%,

doctors by 5.6% and allied health professionals (such as physiotherapists, podiatrists and nutritionists) by 5.1%.

From the point of view of security of employment in our hospitals, it is far better to have nothing whatever to do with patients.

Most of the added expense of the Tasmanian system, compared with other states, comes from the high costs of staff. This is not a factor of high wages – this state pays individual employees less, on average, than their interstate peers – but because staff are so inefficiently used. The THOs are required in their service agreements, for instance, to increase the number of less-qualified and lower-paid enrolled nurses to higher-paid registered nurses. There has been significant progress on this issue over the past five years but there is still much to be done.

There has long been extraordinarily high reliance on very expensive agency nurses and locum doctors, and on paying staff overtime rather than recruiting adequate numbers and scheduling more efficiently. These issues have to some extent been addressed since the state government budget cuts of 2011 but are still far too high.

But the inefficient use of staff is not the only problem. The Tasmanian hospital system pays far too much for drugs and medical supplies, particularly surgical prostheses such as artificial knees and hips. In other jurisdictions, surgeons must order from lists where possible which is based on generic products rather than the much more expensive designer brand. In the private sector, insurers impose such lists and surgeons generally abide by them.

On a weighted per-service basis, Tasmanian public hospitals pay 65% more than the national average for medical supplies and twice the amount paid by the lowest-cost states, Victoria and South Australia. A generic-based list exists for drug purchases but much better prices could be negotiated. In 2010-11, Tasmania paid 26% more than the national average and 32.5% more than Victoria on a weighted per-service basis. If Tasmania's purchasing systems were as efficient as the national average, about \$31 million would have been saved in that year on medical supplies and about \$7 million on drugs. If they were as efficient as Victoria's, the savings would have been about \$40 million for medical supplies and about \$8 million for drugs.

If a purchasing consortium could be established with Victoria, with hospitals in both states ordering from national wholesalers according to common lists, both states would benefit. Victoria's buying power would be increased and because costs have increased since 2011, Tasmania could expect to save, by this single measure, more than \$50 million a year.

Overcrowding is a major cause of economic inefficiency. Although in other areas of the economy the maximum use of facilities is usually regarded as improving cost-effectiveness, unduly high bed occupancy produces the opposite result. The RHH and LGH commonly experience occupancy rates of around 95% to 98%, and often above 100%. Rates much above about 85% involve significant compromises in avoidable infections and other complications, and in the inability to move seriously ill patients out of emergency departments to specialist wards. Access block, as this is known, is associated with increased death-rates of the order of 30%. It also helps cause ambulance ramping, long delays in which ambulances are unable to respond to calls because they are unable to discharge their patients into overcrowded emergency departments.

The rate of overnight separations per 1000 population, a measure of the accessibility of hospitals to the public they serve, are the worst in the country by a considerable margin.

In no Australian public hospital system is access to elective surgery anywhere near to being satisfactory

but Tasmania's record is worse than most. The way elective surgery cases are handled in the state's hospitals is a further large contributor to overall economic inefficiency. A great deal of public attention has been paid to waiting lists, which have been unsatisfactory for many years but which were disproportionately affected by state government budget cuts. The number of raw (that is, unweighted for complexity) elective surgery admissions fell between 2010-11 and 2011-12 by 4% each in the RHH and LGH, 7.5% at the North-West Regional Hospital and 8.75% at the Mersey. Across Tasmania, the fall was 5%.

Hospital-initiated elective surgery cancellation is unacceptably high, and yet another contributor to inefficiency. Publicly available information on this matter is scarce but the overall rate of procedures being cancelled is about 19%, with between 6% of all operations being cancelled after the patient has been admitted.

The dangers to the patient of surgery cancellation are well documented. Overseas studies have shown substantial increases in deaths and complications, massively increased costs and significant social and psychological impacts on patients.

Many of the inefficiencies associated with elective surgery can be addressed. The Alfred Hospital in Melbourne reduced its cancellation rate from 28% to 1% by physically separating low- to medium-acuity cases into a separate centre – where they are isolated from the imperatives of more urgent cases – and by introducing a new patient-flow process.

At the RHH and LGH, this success can be replicated remarkably cheaply by utilising unused and under-used facilities in private sector, and establishing new public hospital elective surgery centres within Calvary campuses in Hobart and Launceston. Because Tasmania's private hospitals operate far more efficiently than their public counterparts, the cost per service could be expected to fall substantially, probably by between 10% and 20%.

In the longer term, though, no Australian state or territory has enough money to meet the ever-rising costs of acute health services. Everywhere, the cost of hospitals has been rising at about twice the rate of state government income and every Australian public system is running from one crisis to the next. The states cannot afford their hospitals but the nation as a whole can; and the Commonwealth, which has taxation and other revenue-raising powers denied to the states, must eventually accept single-funder responsibility for the nation's public hospitals. Until that happens, any improvement in efficiency will be lost in the flood of increasing cost and rising demand.

INEFFICIENCY AND ITS SOURCES

THIS PAPER deals with three converging issues: the waste and inefficiencies in the state's public hospitals; the imbalance of hospital bed occupancy between the public and private sectors; and the need to achieve far better performance in elective surgery by separating at least some of these services from the two major hospitals.

The most fundamental measure of value for money is technical efficiency: what you get for the money and resources you invest. By that measure, Tasmania's public hospital system performs lamentably compared with all other Australian state and territory systems. This table shows how all jurisdictions compare: it shows, comparing like with like by taking into account the differing complexity of the various hospital services, how each system performs. In Tasmania, the average service costs 20.2% more than the national average and 31.2% more than in Victoria, the most cost-efficient state.

Table 1: Cost (\$) per casemix-adjusted separation (excluding depreciation) 2010-11¹

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

Source: AIHW

This paper examines why this is so.

The reasons for this inefficiency are complex, stubborn and opaque. The Tasmanian government's insistence on restricting the release of a great deal of basic information on the condition of the system has greatly compromised reform attempts by successive ministers and has allowed hospitals to defy them. This opacity derives from the short-term political desire to insist – against the evidence – that all is well but in the long term has all but destroyed the government's credibility in health policy. In the absence of informed public discussion, which is not possible without information, the field has been left open to the plethora of vested interests whose aims are not always compatible with the delivery of the best value for money in our public hospitals. There is strong and strident advocacy for everybody except the patients.

The table above shows how important is the control of labour costs in delivering value for money in our health system. But Tasmania is not inefficient because it pays individual staff more than they would get in other states. The national figures show Tasmania pays its doctors, nurses, administrators, clerks and domestic staff less than the national average.² Only diagnostic and allied health professionals are paid more. The critical shortcoming is in the use to which staff are put: whether the systems in place in our hospitals are designed to work as effectively as they should. For example, Tasmania spends more

1 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2010-11*, AIHW, Canberra 2012, p. 44.

2 *Ibid*, p. 88.

on administration labour costs than any other jurisdiction: in 2010-11, \$422 for each weighted separation, against a national average of \$320 and \$241 in South Australia.³ The issue is not trivial. If Tasmania had operated with the standard of efficiency of the average Australian public hospital, \$101.5 million would have been saved and an extra 20,600 patient services could have been given. If the Victorian standard had been reached, \$143 million would have been saved and another 31,700 patient services funded.

Table 2: Cost per casemix-adjusted separation (excluding depreciation) in nominal terms (\$) and percentage changes (year-on-year) 1996-97 to 2010-11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1996-97	2 586	2 353	2 354	2 731	2 309	2 660	3 689	3 179	2 496
% change	na	na	na	na	na	na	na	na	na
1997-98	2 637	2 462	2 354	2 966	2 458	2 739	3 623	3 363	2 575
% change	2.0%	4.6%	0.0%	8.6%	6.5%	3.0%	-1.8%	5.8%	3.2%
1998-99	2 766	2 413	2 390	3 026	2 430	2 568	3 326	3 297	2 611
% change	4.9%	-2.0%	1.5%	2.0%	-1.1%	6.2%	-8.2%	-2.0%	1.4%
1999-2000	2 812	2 529	2 556	3 335	2 579	2 848	3 167	3 444	2 728
% change	1.7%	4.8%	6.9%	10.2%	6.1%	10.9%	-4.8%	4.5%	4.5%
2000-01	2 875	2 761	2 636	2 912	2 723	2 979	3 330	3 355	2 804
% change	2.2%	9.2%	3.1%	-12.7%	5.6%	4.6%	5.1%	-2.6%	2.8%
2001-02	3 010	3 117	2 741	3 180	2 898	3 118	3 769	3 709	3 017
% change	4.7%	12.9%	4.0%	9.2%	6.4%	4.7%	13.2%	10.6%	7.6%
2002-03	3 283	3 285	2 885	3 284	2 796	3 136	4 128	3 603	3 184
% change	9.1%	5.4%	5.3%	3.2%	-3.5%	0.6%	9.5%	-2.9%	5.5%
2003-04	3 451	3 333	2 929	3 422	3 036	3 333	4 002	3 377	3 293
% change	5.1%	1.5%	1.5%	4.2%	8.6%	6.3%	-3.1%	-6.3%	3.4%
2004-05	3 551	3 430	3 057	3 557	3 100	3 642	4 237	3 856	3 410
% change	2.9%	5.9%	4.4%	3.9%	2.1%	9.3%	5.9%	14.2%	3.6%
2005-06	3 852	3 646	3 537	3 733	3 299	3 994	4 250	4 187	3 698
% change	8.5%	6.3%	15.7%	4.9%	6.4%	9.7%	0.3%	8.6%	8.4%
2006-07	4 042	3 853	3 786	4 111	3 436	4 354	4 430	4 580	3 922
% change	4.9%	5.7%	7.0%	10.1%	4.2%	9.0%	4.2%	9.4%	6.1%
2007-08	4 295	4 172	4 172	4 405	3 900	4 605	4 513	4 668	4 232
% change	6.3%	8.3%	10.2%	7.2%	13.5%	5.8%	1.9%	1.9%	7.9%
2008-09	4 454	4 380	4 507	4 842	4 074	4 817	4 624	5 361	4 471
% change	3.7%	5.0%	8.0%	9.9%	4.5%	4.6%	2.5%	14.8%	5.6%
2009-10	4 557	4 591	5 093	4 728	4 374	5 369	4 989	5 517	4 706
% change	2.3%	4.8%	13.0%	-2.4%	7.4%	11.5%	7.9%	2.9%	5.3%
2010-11	4 904	4 508	5 323	4 996	4 854	5 913	5 401	5 645	4 918
% change	7.6%	-1.8%	4.5%	5.7%	11.0%	10.1%	8.3%	2.3%	4.5%
% for series	86.9%	91.6%	126%	83%	110.2%	122.3%	46.4%	77.6%	97%

Source: AIHW

The table above shows the average per-service costs for all jurisdictions since the series began in 1996-97. In that time, Tasmania's costs have grown from the mid-range to the top: at the outset, the state's public hospitals were more cost-effective than those in Western Australia, the ACT and the Northern Territory, and similar to those in NSW. But in nine of the 15 years, Tasmania's percentage increase has been higher than the national average. Over the whole series, Tasmania's per-service costs have risen by 122.3% against the national average of 97%. Only Queensland has a worse record in maintaining

³ *Ibid*, p. 49.

overall economic efficiency.

As with most statistics, these interstate comparisons contain a margin of error, largely because of differences in the details of coding and reporting by various jurisdictions and particular hospitals. Some Tasmanian officials, for instance, believe Victoria is for this reason somewhat less efficient than the figures would indicate. In a paper published as long ago as 2000, a group of Monash University health economists called for the system to be routinely audited at the input – that is, state and hospital – level, but while there have been improvements in the accuracy, consistency and scope of reporting, a proper audit process still needs to be put into place.⁴ Nevertheless, these matters are not significant enough to plausibly change the basic picture, a view confirmed by the Monash study and by the AIHW’s continued use of these measures. The Institute also has a rigorous process of data verification: anything in the raw data that is believed to skew the figures, or which is out of line with historical or comparative data, is questioned and corrected.

The cost per casemix-weighted separation does not include capital expenditure, so Tasmania’s high figures cannot be explained by, for instance, building works at the Royal Hobart or Launceston General hospitals. The figure concentrates on acute care and does not include very small hospitals. Judged on the basis of their national peer-groups, smaller acute hospitals perform comparatively well: this group, though expensive, performs more efficiently than its national peer-group average.⁵ It is in the state’s four major hospitals that the problem – and the scope for massive improvement – exist. The following table compares the per-service cost of principal referral hospitals (in Tasmania, this is the RHH and LGH) with small acute hospitals. In Tasmania there are seven of these small hospitals. Relevant figures for the NWRH and the Mersey are not available.

Table 3: Cost per casemix-adjusted separation, principal referral and small acute hospitals, 2010-11

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Major	4 855	4 395	5 373	4 696	4 820	5 779	5 401	5 595	4 851
Small	6 112	5 556	5 183	7 516	4 158	5 773	na	6 027	5 920

Source: AIHW

The paper will also examine whether the situation in Tasmania has changed substantially since the most recent national figures were collected. It is usual for ministers, when confronted with data showing poor performance, to say that things have changed in the intervening period and the unfavourable data are therefore invalid. No doubt this excuse will be used again. There have indeed been some significant improvements in the economic efficiency of Tasmania’s hospitals, mostly under the pressure of heavy government budget cuts. But other jurisdictions have also been improving and, as we shall see, the progress made in Tasmania is unlikely greatly to change its position relative to the rest of Australia.

4 Jenny Watts, Jeff Richardson, Leonie Segal, *Comparing national public hospital cost data collections for use in performance reporting*, Health Economics Unit, Monash University, September 2000.

5 AIHW, *Australian hospital statistics 2010-11*, pp 51 -54. The AIHW defines small regional acute hospitals as ‘mainly small country town hospitals, acute hospitals treating <2000 separations per annum, and with less than 40% non-acute and outlier patient days of total patient days’. There are six of these in Tasmania. The seventh is ‘small acute’ with fewer than 5000 separations.

INEFFICIENCIES: MORE CLERKS THAN DOCTORS

There are high numbers of administrators within the Tasmanian Health Organisations. At 30 June 2012, staff under the Health and Human Services Award accounted for 36% of total staff numbers. Of these, about two-thirds were clerical and administrative staff: the rest were health services officers, including cleaners, caterers and laundry workers. Some specific figures reported to me informally include 46 staff in the Southern THO human resources unit, and 14 in the North-West business intelligence unit: these specific figures need to be confirmed but are of concern.

Contrary to the popular view, the large majority of administrative staff are not employed in the department's central offices but within the state's public hospitals.

Table 4: Staff in Tasmanian THOs and DHHS head office by award, 30 June 2012 by THO head count and THO percentage of total DHHS employment, and central DHHS office⁶

Award	THO head count	THO % of health	Department
Allied health professionals	1 036	10.25%	15
Ambulance officers	316	3.12%	0
Dental officers	36	0.35%	0
Health & human services*	3 635	36.00%	166
Medical practitioners	785	7.75%	2
No award	16	0.16%	1
Nursing	4 035	40.00%	14
Radiation therapists	50	0.50%	0
Senior executive service	13	0.13%	11
Visiting medical officers	182	1.80%	1
Total	10 104	100.00%	210

Source: DHHS. Percentages do not add to 100% due to rounding. *Includes health service officers

On a per-service basis, Tasmania spends more on administrators and clerks than any other jurisdiction and in 2010-11, the most recent year for which comparative figures are available, 31.9% more than the national average.

Table 5: Administrative labour cost per casemix-adjusted separation, 2010-11⁷

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Cost (\$)	321	272	370	380	241	422	368	341	320
% + or - from av	-0.3%	-15.0%	+15.5%	+18.7%	-24.7%	+31.9%	+15.0%	+6.0%	na

Source: AIHW

The full-time equivalent (FTE) proportions for staff in all categories are generally in line with the head count. About one-fifth of all FTE employees in the three THOs are in administrative or clerical positions. They outnumber doctors almost two to one. It is of significance that the proportion of nurses to all staff, shown in Table 6, is substantially lower in the Southern THO than in the other two regions. The Australian Nursing Federation believes this may be the source of the high (and, for the ANF, unacceptable) levels of overtime and double-shifts demanded of nursing staff at the Royal Hobart

⁶ Department of Health and Human Services, *Response to information request*, November 2012.

⁷ AIHW, *Australian hospital statistics 2011-12*, p 49.

Hospital. But across the state as a whole, the numbers of clinical staff appear to have been cut in response to state government budget cuts far more than clerks, administrators, cleaners and caterers. As Table 7 shows, this is certainly true of the Southern THO.

Table 6: Full-time equivalent staff (FTE) by award, Tasmanian Health Organisations, 8 August 2012.⁸

Award	THO South		THO North		THO North-West	
	FTE	% of THO (S)	FTE	% of THO (N)	FTE	% of THO (NW)
Allied health professional	395.86	11.86%	181.28	8.47%	91.11	7.33%
Dental	26.70	0.80%	na	na	na	na
H&HS award [^]	690.13	20.68%	389.27	18.18%	263.00	21.17%
Health service officers*	570.59	17.10%	412.72	19.28%	223.20	17.97%
Nursing	1 244.05	37.28%	911.98	42.59%	543.43	43.74%
Other	1.00	0.03%	na	na	na	na
Radiation therapist	17.26	0.52%	28.55	1.33%	na	na
Rural medical practitioner	0.68	0.02%	2.28	0.11%	0.54	0.04%
Salaried medical practitioner	370.96	11.12%	194.93	9.10%	111.82	9.00%
Senior executive service	3.00	0.09%	4.00	0.19%	1.00	0.08%
Visiting medical practitioner	16.74	0.50%	16.08	0.75%	8.31	0.67%
Total	3 336.96	100%	2 141.09	100%	1 242.41	100%

Source: DHHS. The THO Governing Councils employ 9.8 FTE staff in addition to the figures above.

[^] Clerical and administrative section of the H&HS Award, bands 1-9. * HSO section of the H&HS Award, bands 1-5.

Table 7: Southern Area Health Service staffing categories (head count) 2010-11 and 2011-12.⁹

Category	2010-11	% (10-11)	2011-12	% (11-12)	% change
Clerical/admin [^]	682	19.6%	668	20.30%	-2.0%
Radiation therapists	18	.5%	17	.5%	-5.5%
Computer systems	2	.1%	1	0%	-50.0%
Central offices award	26	.7%	26	.8%	.0%
Allied health	412	11.8%	391	11.8%	-5.1%
Health services award*	576	16.6%	569	17.2%	-1.2%
Medical practitioners	394	11.3%	372	11.3%	-5.6%
Nurses award	1 348	38.8%	1 233	37.4%	-8.5%
Senior executives	4	.1%	6	.2%	50.0%
Visiting medical officers	18	.5%	17	.5%	-5.5%
Total	3 480	100.0%	3 300	100.0%	-5.2%

Source: Hansard. The two extra senior executive positions are due to the takeover of the Oral Health Service and are not new jobs.

[^] Clerical and administrative section of the H&HS Award, bands 1-9. * HSO section of the H&HS Award, bands 1-5.

This response to a budget cut illustrates why changes to the level of block funding cannot be used as a tool to encourage economic efficiency within hospitals. The government presented the hospital CEOs with an over-riding priority: to cut costs. This was given a far higher priority than improving productivity. Generally, it is easier to remove a nurse or doctor than a public servant. When crude cost-

⁸ DHHS, *Right to information request, RTI 2012-13-0015*, 26 October 2012.

⁹ Hansard, *Evidence to Legislative Council Government Administration Committee A*, Parliament of Tasmania, 16 November 2012.

cutting becomes paramount, there is a strong incentive to target doctors and nurses for removal because they earn more. The undeniable result is that, from the point of view of security of employment in a Tasmanian public hospital, it is far better to have nothing whatever to do with patients.

The state government has tried many times to use the blunt instrument of a hospital's budget to encourage productivity but, as the figures show, they have failed dismally. The result of any restriction in a budget, too often, has been an exercise in book-keeping rather than economics: to cut costs but, by doing so, to cut productivity even more. Casemix (or activity-based) funding, on the other hand, is a highly targeted and flexible system under which a specific price is set for each acute inpatient service. If the service is not performed, the hospital is not paid. If the service is not performed efficiently, the hospital must change its ways because it cannot meet its budget simply by cutting services: if it does that, its budget goes down more. It is no coincidence that the two states which have employed casemix funding for many years – Victoria and South Australia – are the most efficient in the nation.

Too often, it is argued that inter-jurisdictional comparisons are not valid, that Tasmania is a special case, that what works interstate could not work here because we are too small. But our two major hospitals are not small. They do not have the size and throughput of the Royal Melbourne, Westmead or Royal Prince Alfred hospitals but the RHH and LGH are substantial institutions of the second rank. They are not small outfits. And the fact that interstate comparative figures contain a margin of error should not be a reason for disregarding them. For too long, many of our officials and ministers have paid too little attention to the benchmarks which clearly show how Tasmania has become less and less efficient in the whole time since the figures began. Too often, we have compared ourselves only with ourselves.

The time has come for this to change. The benchmarks matter.

INEFFICIENCIES: LABOUR COSTS

In their current service agreements with the state, the THOs are required to bring their ratios of higher-paid registered nurses to lower-paid enrolled nurses more into line with the rest of the nation. The extent to which this has been achieved is not publicly known. Substantial savings are possible: the salary range for less-qualified enrolled nurses is \$49,236 to \$54,527, and for registered nurses from \$53,656 to \$141,892.¹⁰ There are limited roles for enrolled nurses, who must generally work under supervision, and the same ratios are not appropriate to all clinical situations. In 2008 Lara Giddings, then the health minister, told an Estimates hearing that a disproportionate number of registered nurses had been employed in the previous ten years and the ratio of enrolled nurses was 7.06% – which she said was ‘far too low’.

Figures are available from the Australian Institute of Health and Welfare for the state as a whole, but do not give the results for individual hospitals. To compare Tasmania with other states, the most meaningful measure is of the full-time equivalent (FTE) rate: that is, the number of FTE positions per 100,000 of population. It indicates that between 2007 and 2011 the ratio has improved somewhat, with the proportion of enrolled nurses to all nurses rising from 13.6% in 2007 to 16% in 2011.

Table 8: Employed registered and enrolled nurses (FTE) per 100,000 population, 2007 and 2011¹¹

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2007									
<i>Registered</i>	847.3	949.1	872.9	772.1	987.2	1 083.8	926.4	1 271.1	891.5
<i>Enrolled</i>	159.2	275.1	159.2	200.4	299.3	170.3	179.7	160.1	203.2
<i>Total</i>	1 006.7	1 224.4	1 032.3	972.3	1 286.5	1 254.4	1 106.1	1 431.0	1 095.1
2011									
<i>Registered</i>	827.5	907.7	884.9	882.2	1 035.2	1 036.2	999.0	1 374.2	893.0
<i>Enrolled</i>	144.4	242.4	168.1	148.8	316.2	196.9	175.2	123.3	188.1
<i>Total</i>	971.8	1 149.8	1 053.0	1 031.2	1 351.4	1 232.9	1 174.1	1 497.4	1 081.1

Source: AIHW

While it is difficult to extrapolate directly from this statewide figure to the specific situation in our public hospitals, the majority of nurses are employed in the public system so any marked trend probably mirrors the public situation. The Australian Nursing Federation supports this view: according to their figures, around 18% of all nurses in the state’s public hospitals are enrolled. But there is still a long way to go. The ANF industrial agreement with the Tasmanian government permits hospitals to employ up to 25% enrolled nurses where this is clinically appropriate.

This is a legitimate efficiency issue and contributes to the per-service costs of Tasmania’s main hospitals: overall labour costs are about 20% higher than the national average on a per-separation basis; these higher costs are responsible for adding around \$600 to the cost of every service performed by the Tasmanian public hospital system.

These extra labour costs are due to a range of inefficiencies, of which nursing ratios are only one. Others include serious overstaffing as well as inefficient employment and scheduling practices (such as the over-use of locum doctors and agency nurses). Under the pressure of state government budget cuts,

¹⁰ DHHS, *Nurses and midwives heads of agreement 2010; Nurses (Tasmanian Public Sector) Award 2005*; rates effective from 8 July 2012.

¹¹ Australian Institute of Health and Welfare, *Nursing and midwifery workforce 2011*, AIHW, Canberra 2012, p.28.

some of these expenses are now being addressed. These savings, particularly at the Royal Hobart Hospital, are significant though are from a very high base.

Table 9: Overtime costs, Tasmanian public hospitals, 2010-11 and 2011-12¹²

<i>Business unit</i>	2010-11 (\$)	2011-12 (\$)
Southern Area Health Service	10 423 754	6 701 768
<i>Royal Hobart Hospital</i>	<i>10 197 505</i>	<i>6 571 156</i>
Northern Area Health Service	5 675 125	4 957 373
<i>Launceston General Hospital</i>	<i>5 372 947</i>	<i>4 690 251</i>
North-West Area Health Service	2 830 565	2 152 373
<i>North-West Regional Hospital</i>	<i>1 889 214</i>	<i>1 443 746</i>
<i>Mersey Community Hospital</i>	<i>795 600</i>	<i>596 393</i>
Total hospitals	18 929 444	13 811 514
Total DHHS	26 674 722	20 328 794

Source: Hansard

Table 10: Locum doctor costs, Tasmanian public hospitals, 2010-11 and 2011-12¹³

<i>Business unit</i>	2010-11 (\$)	2011-12 (\$)
Southern Area Health Service	2 273 471	184 088
<i>Royal Hobart Hospital</i>	<i>1 989 020</i>	<i>131 089</i>
Northern Area Health Service	4 647 932	3 805 888
<i>Launceston General Hospital</i>	<i>3 144 280</i>	<i>2 477 494</i>
North-West Area Health Service	10 120 124	11 250 276
<i>North-West Regional Hospital</i>	<i>2 676 454</i>	<i>2 173 022</i>
<i>Mersey Community Hospital</i>	<i>5 932 663</i>	<i>7 341 022</i>
Total hospitals	17 041 527	15 240 252
Total DHHS	18 682 114	16 519 123

Source: Hansard

Table 11: Agency nursing costs, Tasmanian public hospitals, 2010-11 and 2011-12¹⁴

<i>Business unit</i>	2010-11 (\$)	2011-12 (\$)
Southern Area Health Service	1 445 282	348 530
<i>Royal Hobart Hospital</i>	<i>1 399 058</i>	<i>251 056</i>
Northern Area Health Service	831 265	347 545
<i>Launceston General Hospital</i>	<i>109 311</i>	<i>0</i>
North-West Area Health Service	3 290 789	2 949 076
<i>North-West Regional Hospital</i>	<i>502 480</i>	<i>19 235</i>
<i>Mersey Community Hospital</i>	<i>968 112</i>	<i>376 197</i>
Total hospitals	5 567 336	3 645 151
Total DHHS	6 029 507	3 689 379

Source: Hansard

Together, these three cost control measures – overtime, agency nurses and locum doctors – saved \$10,849,047 in 2011-12, compared with the previous year. This is useful, but the operating costs of Tasmania’s acute health services were over a billion dollars – \$1,003,997,000 – in that year. Saving

12 Question on Notice 174, *Health – Miscellaneous costs*, Hansard, Legislative Assembly, Parliament of Tasmania, 27 September 2012, p. 105.

13 *Ibid.*

14 *Ibid.*

\$10.8 million will not make much difference to the bottom line or to the per-service cost.

Cancellation of surgery can also add to labour costs when surgeons and other high-paid staff are unable to work, and where the costs associated with preparing patients for surgery and accommodating them in acute beds for a greater-than-necessary length of stay are wasted. The staff reductions undertaken in response to state government budget cuts have been achieved without a significant reduction in weighted admissions, though elective surgery has been hard and disproportionately hit and the failure to increase admissions in the face of continually rising demand means Tasmania's hospital system is falling further and further behind. But these efficiency gains, late and little as they are, are to be welcomed. They are a start but much more needs to be done. The question is whether, if the pressure of budget cuts is lifted, the imperative to achieve greater efficiency will be maintained.

INEFFICIENCIES: PURCHASING

A significant area of inefficiency is in the purchase of drugs and, particularly, therapeutic devices such as stents and artificial hips and knees. As in the pharmaceutical market, there is often a very large difference in the price of designer-brand products and their equally effective generic equivalents. In other states, surgeons are required to use products from an approved list which makes the most of the generic competition. In the private system, such lists are enforced not by the hospitals but by the private insurers. The savings can be very substantial. In Tasmanian public hospitals there is no such list: surgeons order whatever they like.

The solution is obvious. A list of prostheses and other devices, based initially on lists from interstate hospitals and developed in consultation with Tasmanian surgeons, should be established and enforced. If the list is intelligently constructed there will be no downside for individual patients but a significant benefit for the system as a whole.

In the similar field of drug supplies, the Tasmanian system does a somewhat better job. The pharmacy list is based on generics which, wherever they are available, are almost invariably bought. Higher-priced originator-company brands are only bought when they remain in patent and have no cheaper generic equivalent. Individual pharmacies order what they need, based on this list. Nevertheless, the Tasmanian hospitals spend more per casemix-adjusted separation on drugs than any other jurisdiction.¹⁵

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

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Medical supplies	540	390	582	332	335	780	467	414	471
Drug supplies	254	239	257	267	238	317	144	243	250

Source: AIHW

For drugs it costs 26% more to treat the average patient than the national average and 32.5% more than in Victoria and South Australia. For medical supplies, Tasmania spends 100% more per service than in Victoria – twice as much – and 135% more than in South Australia. It is not possible, from the data the state government has released, to calculate precise possible savings but approximate figures indicated that if Tasmania's purchasing systems were as efficient as the national average, about \$31 million would have been saved in 2010-11 on medical supplies and about \$7 million on drugs. If they were as efficient as Victoria's, the savings would have been \$40 million for medical supplies and \$8 million for drugs.

If a purchasing consortium could be established with Victoria, with hospitals in both states ordering from national wholesalers according to common lists, both states would benefit. Victoria's buying power would be increased and on current costs Tasmania could expect to save, by this single measure, at least \$50 million a year.

¹⁵ AIHW, *Australian Hospital Statistics 2010-11*, p. 49.

INEFFICIENCIES: OVERCROWDING

Data from 2012 show the Royal Hobart and Launceston General hospitals operate with at least 95% occupancy; 98% is more usual and in peak periods the rate is likely to exceed 100%.¹⁶ The situation remains the same as the year before.¹⁷

Table 13: Average inpatient bed occupancy rates, major Tasmanian hospitals, 2010-11

<i>RHH</i>	<i>LGH</i>	<i>NWRH/MCH</i>
98%	97%	81.5%

Source: DHHS

There is no ideal magic number but it is widely accepted – and well documented – that rates much in excess of about 85% involve significant safety compromises in terms of increased infections, avoidable complications and medical mistakes. In Britain a report by the independent Dr Foster’s Intelligence organisation (part owned by the Health Department) reports that National Health Trust hospitals are ‘full to bursting’ with midweek occupancy rates around 88% and 90% at weekends.¹⁸

In Tasmania, there are also problems with scheduling, surgery and consultation cancellations, and the dangerous situation in which specialist services – such as intensive care or specialist stroke beds – are not available. Overcrowding on the wards means even fairly minor peaks in demand cannot be dealt with. Coping with a major emergency, such as a bushfire, plane crash or terrorist attack with large-scale casualties, is out of the question.

Access block and ambulance ramping in emergency departments is usual. Access block is associated with a 30% increase in mortality: seriously ill patients in need of specialist care are particularly vulnerable in our present system.¹⁹ No state does a good job in providing emergency department care: extended waiting times and access block are common around the nation. Recent Commonwealth data shows how Tasmanian hospital rank against their peers in other states.²⁰

The Royal Hobart and Launceston General hospitals are classified in the ‘major regional hospitals’ peer group. The data, published by the National Health Performance Authority in December 2012, shows that in 2011-12 it took an average of 28 hours for people in need of inpatient care to be admitted to the hospital at the LGH and 13½ hours at the RHH, against a peer-group average of 17 hours. At the LGH, 38% took longer than four hours to be dealt with and to depart; at the RHH, it was 44%, against a national peer group average of 37%.

The situation is better in the north-west, where demand is lower and the Commonwealth funds the Mersey Community Hospital. The North-West Regional Hospital admitted 90% of ED patients within ten hours (against its ‘large regional’ peer-group average of 12 hours 24 minutes, and 81% had departed within four hours, against 78% across the nation.

16 Hansard, *Evidence to Legislative Council Government Administration Committee A*, Parliament of Tasmania, Hobart 16 November 2012.

17 Michelle O’Byrne, Estimates Committee A – Part 1, *Hansard*, Parliament of Tasmania, 28 June 2011.

18 Denis Campbell, Hospitals ‘full to bursting’ as bed shortage hits danger level, *The Observer*, 2 December 2012.

19 Roberto Forero, Ken Hillman, *Access block and overcrowding: a literature review*, Simpson Centre for Health Services Research, University of NSW, Sydney 2010.

20 National Hospital Performance Authority, *Hospital performance: Time patients spent in Eds in 2011-12*, Department of Health and Ageing, Canberra, December 2012, p.21.

At the Mersey, which falls within the ‘medium hospital’ peer group, the 90% admission rate took 11 hours (against 12 hours 15 minutes) and 79% departed within four hours (against 76%).

The situation at the LGH has improved somewhat since the establishment of an acute medical unit (AMU) next to the emergency department. This unit allows the early assessment and care of acute patients, taking them out of the ED. As a result of this reform, length of stay (LOS) in three key wards was reduced from 11.65 days to 8.79 days. In the AMU itself, LOS improved still more.²¹

The AIHW is in the process of reporting more comprehensively on markers of the relative safety and quality of care in Australian hospitals. Many of these indicators are not yet available but data on *Staphylococcus aureus* (golden staph) infections and overnight separations per 10,000 patient days are published in the *Australian Hospital Statistics* reports.

As the AIHW notes, rates of hospital-associated infection are ‘an indicator of the safety of care. Patients who develop bloodstream infections such as SAB (*S. aureus* bacteraemia) are more likely to suffer complications that result in a longer hospital stay and an increased cost of hospitalisation. Serious infections may also result in death.’ In response to an intensive hand-washing campaign, the Tasmanian rate of overall SAB has improved significantly from being the highest in the nation and is now below the national average. However, overall Tasmanian numbers of hospital-associated SAB infection are low and trends should be interpreted with caution.

Table 14: Cases of *S. aureus* bacteraemia per 10,000 patient days in public hospitals 2010-11 & 2011-12^{22,23}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2010-11									
Methicillin resistant SAB	0.4	0.2	0.3	0.2	0.2	0.2	0.2	0.6	0.3
Methicillin sensitive SAB	0.9	0.7	0.9	0.9	0.7	1.1	0.7	0.8	0.8
Total	1.2	0.9	1.2	1.0	0.9	1.3	0.9	1.4	1.1
2011-12									
Methicillin resistant SAB	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.5	0.2
Methicillin sensitive SAB	0.7	0.8	0.7	0.6	0.6	0.7	1.0	0.8	0.7
Total	1.0	0.9	0.9	0.7	0.9	0.8	1.1	1.3	0.9

Source: AIHW

Recent data issued by the Tasmanian Department of Health and Human Services do not give an annual statewide rate and are not therefore directly comparable with the AIHW data. The DHHS reports that the mean average rate of healthcare associated SAB in acute public hospitals was 1.04 per 10,000 patient days between 1 July 2009 and 30 September 2012.²⁴

On another key measure, Tasmania performs less well. The population-adjusted rate of overnight separations – that is, patients who spend at least one night in hospital – is regarded as an indicator of the accessibility of hospital services.

21 DHHS, *Annual report 2011-12, Part 2: Our direction*, p.47.

22 AIHW, *Australian hospital statistics 2010-11*, p.32.

23 AIHW, *Australian hospital statistics 2011-12: Staphylococcus aureus bacteraemia in Australian public hospitals*, Canberra, January 2012, p.7.

24 Brett Mitchell, Alistair McGregor, Anne Wells, Fiona Wilson, *Tasmanian Acute Public Hospitals Healthcare Associated Infection Surveillance Report no.15*, DHHS Hobart December 2012.

Table 15: Overnight separations per 1000 population, public hospitals, 2010-11²⁵

<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
114.5	111.3	103.8	111.4	118.7	92.2	128.2	189.4	112

Source: AIHW

On this measure, Tasmania's public hospitals are the least accessible in the nation. It cannot be explained by the general health status of Tasmanians, whom one would expect to need more, not fewer, hospital services than most other Australians.

²⁵ AIHW, *Australian Hospital Statistics 2010-11*, p.38.

A SPECIAL CASE: ELECTIVE SURGERY

MUCH OF the public discussion about the shortcomings of Tasmania’s public hospital system concerns elective surgery waiting lists. These are indeed serious: of those on the official elective surgery waiting list, only 68% statewide were treated within the clinically recommended time. At the RHH the figure was 60% in the first quarter of calendar 2012 and 58% in the second quarter.²⁶

In the second quarter, waiting times at the RHH varied from 25 days for a coronary artery bypass graft to 403 days for a cataract extraction, 422 days for eardrum repairs, 295 days for a hip replacement and 679 days for a knee replacement.

At the LGH in the same quarter, cystoscopy was the quickest reported procedure at 20 days: others included cataracts (623 days), hip replacements (238 days) and knee replacements (312 days). Figures for haemorrhoid operations were not reported in the second quarter at this hospital but were 724 days in the first quarter.

There is a waiting list to get on the waiting list. The times taken before a patient can see a specialist for the first time are not routinely published and are difficult to obtain. The figures for the RHH were published by the former division of general practice in its regular newsletter but the organisation’s successor, the Tasmanian Medicare Local – despite receiving very large amounts of government funding – has ceased to make these data available. The most recent available detailed data, therefore, are below.

**Table 16: Waiting times for first appointments at surgical clinics (weeks)
Royal Hobart Hospital, October 2011**

Urgency	Neurosurgery			Ophthalmology			Orthopaedics			Paed. Surgery			Surgical A			Surgical B			Surgical C		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Min	0	38	108	16	30	78	1	6	54	1	1	31	7	48	44	5	9	15	5	40	42
Max	0	92	144	19	43	90	1	6	54	8	8	32	32	75	105	4	25	20	36	60	62

Source: General Practice South

A: urgent; B: semi-urgent; C: next available.

In an answer to a parliamentary Question on Notice the Minister for Health, Michelle O’Byrne, released the following average figures for 18 July 2012. She said the DHHS could not readily track these data across time periods: though this information was asked for, it was not given. It is almost impossible to compare the data below with those in the table above. It is not therefore possible to say whether the situation is getting better or worse.

²⁶ *Progress chart*, September 2012, DHHS, Hobart 2012, p 29.

Table 17: Elective surgery outpatient clinic waiting times for first consultation (days), 18 July 2012²⁷

Category	THO South	THO North	NWRH	Mersey
A	182	63	40	32
B	294	172	83	66
C	294	265	104	119

Source: Hansard

However, the number of people being admitted for elective procedures declined significantly in all four major public hospitals between 2010-11 and 2011-12, probably in response to state government budget cuts which have disproportionately hit elective surgery. The following table includes some medical admissions: some elective surgery patients also require attention from physicians.²⁸

Table 18: Admissions from elective surgery waiting list, 2010-11 and 2011-12

	RHH	RHH	LGH	LGH	NWRH	NWRH	Mersey	Mersey
	2010-11	2011-12	2010-11	2011-12	2010-11	2011-12	2010-11	2011-12
General surgery	1 143	1 231	1 012	1 039	887	768	573	662
Orthopaedic	756	705	757	779	463	510	265	291
Plastic/reconstructive	990	1043	673	625	-	-	-	-
Ophthalmology	376	474	522	393	-	-	626	388
Ear, nose and throat	569	488	450	448	109	127	29	37
Urology	800	793	1 091	1 028	-	-	208	155
Neurosurgery	335	287	-	-	-	-	-	-
Gynaecology	606	651	752	750	536	457	102	63
Cardiothoracic	457	413	-	-	-	-	-	-
Vascular, endovascular	197	125	63	85	-	-	44	6
Paediatric surgery	326	300	-	-	-	-	-	-
Oral maxillo facial surg	88	75	-	-	-	-	-	-
Gynaecology	149	144	-	-	-	-	-	-
Paediatric medicine	112	10	-	-	-	-	-	1
Dermatology	87	40	30	27	-	-	-	-
Obstet/gynaecology	56	22	-	-	87	71	152	184
Cardiology	18	-	-	12	-	-	-	-
Anaesthetics	11	-	-	-	-	-	-	1
Colorectal surgery	-	-	-	1	-	-	-	-
Obstetrics	11	2	-	-	-	-	1	1
Dental surgery	-	4	-	-	-	-	1	1
Haematology/oncology	3	7	-	-	-	-	-	-
Respiratory medicine	1	1	32	-	-	-	-	-
Head & neck surgery	1	-	-	-	4	1	73	103
Gastroenterology	-	-	-	-	1	1	11	10
General medicine	-	-	-	-	1	-	-	-
Renal medicine	1	-	-	-	-	-	-	-
Total	7 085	6 815	5 382	5 187	2 088	1 935	2 085	1 903

Source: Hansard

The rate of decline in raw admissions between 2010-11 and 2011-12 was five per cent: from 16,640 to 15,840.

27 Question on Notice 173, *Health – Miscellaneous costs*, Hansard, Legislative Assembly, Parliament of Tasmania, 27 September 2012, p. 104.

28 Hansard, Question without Notice 180, Legislative Assembly, Parliament of Tasmania, 24 October 2012.

Table 19: Percentage decline in elective surgery admissions, 2010-11 to 2011-12

RHH	LGH	NWRH	Mersey	Tasmania
-4%	-4%	-7.5%	-8.75%	-5%

Source: Hansard

If one assumes a rule-of-thumb that overall demand rises, on average, by around three per cent a year, this indicates that Tasmania's public hospitals in this single year are likely to have fallen behind by about eight per cent in their capacity to meet the needs of Tasmanian elective surgery patients. As time goes by, the situation appears to be getting worse. In the September quarter of 2012, there were far sharper percentage falls in elective surgery admissions compared with the same quarter of 2011 in all major hospitals except the Mersey.

Table 20: Admissions from elective surgery waiting lists and percentage change September quarter, 2011 and 2012

RHH			LGH			NWRH			Mersey		
2011	2012	Change	2011	2012	Change	2011	2012	Change	2011	2012	Change
1 908	1 742	-8.7%	1 522	1 194	-21.6%	586	475	-18.9%	454	496	+9.3%

Source: DHHS

For the four hospitals combined, the number of elective surgery admissions fell by 12.6% between the two quarters, from 4470 to 3907.

A less-discussed contributor to economic and clinical inefficiency is the cancellation rate for elective surgery. This massively contributes to cost, particularly if the patient has already been admitted. This means a waste, usually of at least a day, in the use of an acute hospital bed and of preparing a patient for surgery; and sometimes the surgeon and theatre staff – who must be paid – are prevented from working. It is, of course, highly distressing and sometimes clinically damaging to patients. It further contributes to overcrowding and lengthens waiting lists.

Throughout the developed world, similar sets of reasons for surgery postponement have been found. Some are postponed for medical reasons, such as the patient developing an infection or another co-morbidity which would make surgery unacceptably dangerous.²⁹ But most are deferred for organisational reasons, including elective surgery having to give way to emergency cases,³⁰ non-availability of operating theatres,³¹ over-run of previous operation, lack of post-operative beds, administrative error, poor communication and no surgeon or other key theatre staff.³²

The Tasmanian government seldom releases detailed information on surgery cancellations but the data for seven months of 2011 were given in response to a Right to Information request by the Liberal

29 Georgios Tagarakis, Dimos Karangelis, Christos Voucharas at al, Why are heart operations postponed? *Journal of Cardiothoracic Surgery*, 2011, vol 6, p 106.

30 A Nasr, K Reichardt, K Fitzgerald at al, Impact of emergency admissions on elective surgical workload, *Irish Journal of Medical Science*, 2004, vol 173, pp 133-135.

31 Tagarakis at al, *ibid*.

32 William Schofield, George Rubin, Michael Piza et al, Cancellation of operations on the day of intended surgery at a major Australian hospital, *Medical Journal of Australia*, 20 June 2005, vol 182, pp 612-615.

shadow minister, Jeremy Rockliff.³³

Table 21: Hospital initiated elective surgery postponements, 1 May 2011 to 30 November 2011

Reason	RHH		LGH		NWRH		Mersey		Total	
	Pre-adm	Post adm	Pre-adm	Post adm	Pre-adm	Post adm	Pre-adm	Post adm	Pre-adm	Post adm
Administration	30	2	0	0	19	0	1	0	50	2
Anaesthetist unavailable	2	1	1	0	6	4	22	2	31	7
Incomplete patient prep	3	2	5	8	0	0	1	0	9	10
More urgent elect case	116	5	169	6	39	0	28	0	352	11
No appropriate beds	1	0	0	1	1	0	0	0	2	1
No beds	18	9	3	12	10	0	1	0	32	26
No ICU beds	9	2	1	3	0	5	0	0	10	6
Over-riding emergency	288	39	93	75	9	1	2	0	392	115
Patient admitted, treatment deferred	3	118	0	0	1	16	0	39	4	173
Surgeon unavailable	100	3	72	1	25	0	40	0	237	4
Surgeon postponed	45	6	71	9	45	6	18	0	179	21
Theatre equipment unavailable	8	3	12	5	5	0	1	0	26	8
Theatre list overbooked	10	0	7	0	4	0	2	0	23	0
Theatre ran out of operating time	4	38	10	111	0	2	0	0	14	151
Theatre staff unavailable	15	4	0	0	1	0	0	0	16	4
Subtotal	652	232	444	231	165	35	116	41	1 377	539
TOTAL	884		675		200		157		1 916	

Source: DHHS

Together, ‘over-riding emergency’ and ‘more urgent elective case’ account for almost half of all postponements, both pre- and post-admission. In Tasmania’s major public hospitals, the table above shows the most frequent reason for postponement is that elective patients have to give way either to emergency cases or to more urgent elective cases. But other causes indicate an urgent need to review administrative procedures, particularly in the RHH and LGH. The present situation appears to have gone on for many years, has resisted previous attempts to change it, and cannot be tolerated any longer.

A limited amount of more recent Tasmanian data was given by the chief executive of the RHH, Jane Holden, in her testimony to the recent Legislative Committee hearing. A total of 59 procedures were cancelled in the July-to-September quarter of 2012 due to bed unavailability, a significant rise on the numbers above. She did not give any details of cancellations for other reasons, or for the total number of cancellations at that hospital.³⁴ Nor are data publicly available on the percentage rates of surgery postponements in Tasmania’s public hospitals.

A large number of post-admission cancellations, particularly at the Royal Hobart Hospital, are in a category called ‘patient admitted treatment deferred’. This is a catch-all category but is likely to include a substantial number of people whose condition has rendered them, in the weeks, months or years since their initial consultation, inappropriate for surgery. This can be for many reasons, including co-morbidities such as transient infections. But many of these cancellations could be avoided by a more rational patient-flow process, which would include improvements to the clinics which are held to re-evaluate patients before admission. It may be that these clinics are at present being held too long before the scheduled surgery; and patients whose procedures are postponed are clearly more likely to develop

33 DHHS, *Right to information request RTI 2011-12-0037*, March 2012.

34 Hansard, *Evidence to Legislative Council Government Administration Committee A*, Parliament of Tasmania, 16 November 2012.

a co-morbidity during the period of unforeseen delay.

During 2012 the situation became worse. A greater proportion of total cancellations were made after the patient was admitted – a serious situation from the point of view of cost effectiveness, disruption to the hospital and distress to the patient.

Table 22: Hospital initiated elective surgery cancellations, and percentage of all cancellations made after admission, 1 November 2011 to 30 September 2012³⁵

	<i>Pre-admission</i>	<i>Post-admission</i>	<i>% post</i>	<i>Total</i>
RHH	955	353	27%	1 308
LGH	573	363	39%	936
NWRH	215	36	14%	251
Mersey	101	53	34%	154
Total	1 844	805	30%	2 649

Source: DHHS

The extra squeeze on elective surgery facilities has meant an increase in post-admission cancellations, particularly in the ‘no beds’ category. The extraordinary number of cancellations at the RHH and LGH made because theatres ran out of time reflects poorly on scheduling and administration.

Table 23: Post-admission elective surgery cancellations, 1 November 2011 to 30 September 2012³⁶

<i>Reason</i>	<i>RHH</i>	<i>LGH</i>	<i>NWRH</i>	<i>Mersey</i>	<i>Total</i>
Administration	7	0	1	0	8
Anaesthetist unavailable	0	0	0	0	0
Incomplete patient prep	12	11	0	0	23
More urgent elect case	3	6	7	2	18
No appropriate beds	3	1	0	0	4
No beds	60	59	1	0	120
No ICU beds	3	14	2	0	19
Over-riding emergency	40	139	0	0	179
Patient admitted, treatment deferred	93	0	18	51	162
Surgeon unavailable	6	4	1	0	11
Surgeon postponed	13	11	4	0	28
Theatre equipment unavailable	2	3	0	0	5
Theatre list overbooked	4	0	1	0	5
Theatre ran out of operating time	99	106	1	0	206
Theatre staff unavailable	8	9	0	0	17
TOTAL	353	363	36	53	805

Source: DHHS

Information is not publicly available on the precise rates of cancellation. However, a fairly accurate idea of these rates can be gained from information made available to Parliament in the form of questions on notice and right to information requests from MPs.^{37 38}

35 Right to Information request RTI 2012-13-0026, 24 October 2012.

36 RTI 2012-13-0026, 24 October 2012.

37 Hansard, Question without Notice 180, Legislative Assembly, Parliament of Tasmania, 24 October 2012.

38 RTI 2012-13-0026, 24 October 2012.

Table 24: Rates of elective surgery cancellation, 1 October 2011 to 31 September 2012

	<i>RHH</i>	<i>LGH</i>	<i>NWRH</i>	<i>Mersey</i>	<i>Tasmania</i>
Admissions	6 590	4 766	1 817	1 930	15 103
% cancelled	21.6%	21.4%	15%	8.7%	19.1%
% post- admission	5.8%	8.3%	2.1%	3%	5.8%

Source: DHHS. 12-month figures for cancellations have been extrapolated from 11-month data.

This is further complicated by the number of patients who experience more than one cancellation.³⁹

**Table 25: Number of times individual patients experienced elective surgery cancellations
1 November 2011 to 1 November 2012**

<i>Times cancelled</i>	1	2	3	4	5	6-10	>10
Royal Hobart Hospital	863	162	25	9	0	1	0
Launceston General Hospital	615	105	33	3	0	0	0
North West Regional Hospital	187	26	4	0	0	0	0
Mersey Community Hospital	122	16	0	0	0	0	0
Total patients	1787	309	62	12	0	1	0
Total cancellations	1787	618	186	48	0	10	0

Source: DHHS.

High rates of elective surgery cancellation can have serious implications not only for the economic efficiency of the hospital and therefore its ability to meet demand but also on complications and mortality. Sometimes the cost of the poor organisation, management and policy which produces these results is paid with the lives of patients. A Canadian study of death rates among patients undergoing elective coronary artery bypass grafts (CABG) whose operations were performed as planned were only two-thirds as likely to die as those experiencing surgery postponements.⁴⁰

A large American study in 2010 examined the results of 87,318 CABG procedures, 46,728 colon resections, and 28,960 lung resections.⁴¹ For CABG patients experiencing surgery postponements, infections increased from 5.7% (where the procedure was performed on the day of admission) to 18.2% when it was delayed by six to ten days. Similar increases were noted for lung resection (10.2% to 20.6%) and colon resection (8.4% to 21.6%). In all three categories, increased mortality was strongly associated with delay. Costs also increased. Delays boosted the overall mean average cost of treatment in CABG from \$US36,079 to \$US47,527; in colon resection from \$US20,265 to \$US29,887 and in lung resection from \$26,323 to \$US30,571.

The psychological and social impacts of surgery delay on patients should also not be discounted. A Dutch group used standard, validated questionnaire methods to study the general health perceptions, quality of life and anxiety levels among patients being treated surgically for varicose veins, inguinal hernia and gallstones. They found substantial problems across all these measures in all three patient groups. Emotional reactions to waiting were most negative, not surprisingly, among those waiting for

39 RTI 2012-13-0026, 24 October 2012.

40 Boris G Sobolev, Guy Fradet, Robert Hayden et al, Delay in admission for elective coronary-artery bypass grafting is associated with increased in-hospital mortality, *BMC Health Services Research*, 2008, vol 8, p 185.

41 Todd R Vogel, Viktor Y Dombrovskiy, Stephen F Lowry, In-hospital delay of elective surgery for high volume procedures: The impact on infectious complications, *Journal of the American College of Surgeons*, December 2010, vol 211, no 6, pp 784-790.

gallstone operations. But all groups suffered increased pain and discomfort, mobility problems, anxiety and depression. There were also practical social and financial problems, including extended and unforeseen absences from work.⁴²

Though the new National Efficient Price for activity-based funding may be controversial and in need of further development, it indicates the extent to which Tasmanian hospitals are falling behind their peers in delivering value for money.

Table 26: National efficient DRG price and average Tasmanian actual costs, October 2012⁴³

<i>Procedure</i>	<i>DRG</i>	<i>NEP (\$)</i>	<i>Tas price (\$)</i>	<i>% above NEP</i>
Knee replacement	I04B	20 923	23 505	12%
Hip replacement	I103B	22 176	25 561	15%
Cataract removal	C16Z	2 902	3 232	11%
Cholecystectomy	H08A	13 892	16 277	17%
Hernia repair	G10B	5 033	5 700	13%
Tonsillectomy	D11Z	3 412	3 878	14%
Spinal fusion & deformity	I06Z	63 540	67 341	6%
Spinal fusion w complications	I09A	54 502	61 759	13%
Spinal fusion w/o complications	I09B	31 312	35 434	13%

Source: DHHS

This is of the greatest importance: if the available health money is not spent in ways which obtain the best health outcomes, the price is paid not by hospital executives but with the lives and health of ordinary citizens. This is an economic issue, but it is a moral issue too of the highest dimension.

⁴² J P Oudhoff, D R M Timmermans, D L Knol *et al*, Waiting for elective surgery: Impact on health related quality of life and psychosocial consequences, *BMC Public Health*, vol 7, no 164, 2007.

⁴³ DHHS, *Response to information request*, November 2012.

SEPARATING ELECTIVE SURGERY

Fortunately, there is no shortage of strong evidence about what to do. Two related strategies have been demonstrated to work elsewhere. The first is a separation, preferably physical and not just administrative, of elective from emergency surgery. The second is the introduction of well-designed, protocol-led processes to handle the flow of all surgical patients, particularly those in the new elective-only facilities. In the Australian context, the best-documented examples of highly successful initiatives are to be found at the Alfred and Austin hospitals in Melbourne. Centres to handle a substantial share of those hospitals' elective surgery caseload were established, concentrating on low- to medium-acuity patients

The Alfred Centre was opened in February 2007, recognising that a separate centre would not only provide extra facilities but that, more importantly, it would physically insulate elective patients from the competition from emergency cases. If a separation is created within the same facilities, the danger remains that emergency imperatives will overcome any administrative arrangements that may be in place.

The centre has 26 overnight surgical beds and 55 recovery beds, and concentrates on patients with an expected length-of-stay (LOS) of three days or less. A comprehensive and peer-reviewed study tracked the hospital's performance in elective surgery over five years – from two years before the changes until three years after.⁴⁴

The results are impressive. Hospital-initiated postponements (HIP) fell from 28%, to 1% in the new centre and 7% in the main hospital. There was a 45% decrease in the numbers of semi-urgent patients waiting longer for surgery than the recommended 90 days. LOS for the top ten surgical DRGs dropped from 4.8 days to 2.3 days. The rate of successful same-day discharge rose from 83% to 95%. This is despite an overall increase in elective surgery admissions of 70% over the study period.

But the researchers say these results could not have been obtained on the basis of the increased facilities alone. They also attached great importance to a comprehensive clinical redesign, which they described this way:

With a focus on the patient journey from initial referral to discharge, the redesigned surgical care model was streamlined, standardised and protocol-led. It incorporated patient screening and allocation to an appropriate ward by the perioperative coordinator; one-day attendance at a pre-admission clinic for pre-surgical evaluation and investigations; and coordination of individually tailored discharge support before admission. The redesigned processes became part of standard operating practices for all the elective surgery patients and facilitated the development of admission and activity targets.

The Austin's new elective surgery centre concentrates on the same low- to medium-acuity patient cohort as as the Alfred. It has four theatres, 20 beds and 16 recliner chairs. In 2007-08, before the centre opened, the HIP rate was at 13.5%; by 2011 it had fallen to 7.7%. The proportion of category 2 (semi-urgent) patients being treated within 90 days increased from 35% to 80%, despite a 15% increase in caseload.⁴⁵

As we have seen, occupancy rates in the state's two major hospitals are dangerously high. But a

44 Judy Lowthian, Andrea Curtis, Bernadette Comitti et al, Streamlining elective surgery care in a public hospital: the Alfred experience, *Medical Journal of Australia*, 2 May 2011, vol 195, pp 448-451.

45 Sue Dunlevy, Initiative by hospitals saves time for patients, *The Australian*, 6 August 2011.

different situation exists in the private system, particularly at the Calvary campuses at Lenah Valley and St John's in Hobart and St Vincent's in Launceston. Lenah Valley has a usual occupancy rate of 70%, though many of the under-used beds are in the maternity, rather than surgical, wards. St John's has a high occupancy rate for rehabilitation – about 90% – but 55% in its surgical wards. St Vincent's has an overall occupancy rate of around 60%, with other large areas capable of being relatively easily turned into, or returned to, wards and theatres.⁴⁶

This imbalance can and should be addressed in three ways: by opening unused beds and theatres within the existing public hospitals; by addressing the serious, costly and sometimes dangerous inefficiencies in our major public hospitals; and by physically separating elective from emergency surgery by making use for public patients of under-utilised facilities within the private system.

⁴⁶ Calvary Healthcare, *Personal communication*, November 2012.

MONOPOLY OR COMPETITION?

The Productivity Commission report on the relative efficiency of public and private hospitals shows that, nationally, there is not much to choose between them.⁴⁷ In Tasmania, it is a different story. There are many reasons for this but one may be the lack of effective competition within the public sector. Unlike other jurisdictions, Tasmania has no public hospitals which are owned and operated by non-government operations. On the mainland the Catholic system, for instance, includes 21 public hospitals including seven major teaching hospitals. The result is that the major Tasmanian hospitals operate as monopolies: in each region, there is no other hospital to compete for public patients or, with only minor exceptions, for government funding.

But does competition make public hospitals more efficient? Several recent studies suggest it can, if it's driven by good policy. Recent policy changes in the British National Health Service gave researchers a chance to answer this question, to find out whether public hospitals fared differently when exposed to competition from other public, and from private, hospitals. Under staged reforms introduced by the previous Blair and Brown Labour governments, competition was introduced from other public hospitals in 2006 and from private hospitals in 2008. Patients were given the ability to select the hospital they attend for surgery (a situation that already exists for public hospitals in most Australian cities); the government gave public hospitals extra fiscal and managerial autonomy (as in Australia's National Health Reforms) and a fixed case-based pricing system was introduced along the lines of the casemix (or activity-based) system that is being introduced in Australia and that has long existed in Victoria and South Australia.

A study by researchers at Bristol University in England found that competition between public hospitals in the same catchment area saved lives without raising costs.⁴⁸ Two studies from the London School of Economics confirmed the Bristol findings. Cooper *et al* found that such competition produced a substantial decrease in 30-day mortality rates.⁴⁹ A further study by the LSE group concluded that competition between public-sector hospitals led to reductions in pre-surgery length of stay (LOS) of 9%, overall length of stay by 5% and increased the rate at which patients received care on the day of admission by 4%. They found no evidence that hospitals were induced to discharge patients 'sicker and quicker' than before. But they found the opposite effects when public hospitals were exposed to direct competition from private hospitals: in this case, their LOS actually increased after this phase of competition was introduced, probably because the private hospitals attracted a healthier population, leaving the sicker ones disproportionately in the public system.⁵⁰

This sort of GP-informed patient choice already exists in many parts of Australia and is likely already to be producing these efficiencies; but not in Tasmania, with our geographic (and historic) public sector monopolies. If competition efficiencies are to be realised, there must be more than one supplier in the public hospital arena. And if the notion of the DHHS becoming a purchasing authority to buy the best available services at the best price is to have any practical meaning, there must be more than one seller.

47 Productivity Commission, *Public and private hospitals*, Research report, Canberra 2009.

48 Martyn Gaynor, Rodrigo Moreno-Serra, Carol Propper, *Death by market power: Reform, competition and patient outcomes in the National Health Service*, University of Bristol, August 2011.

49 Zack Cooper, Stephen Gibbons, Simon Jones, Alistair McGuire, Does hospital competition save lives? Evidence from the English NHS Patient Choice reforms, *Economic Journal*, vol 121, pp 228-260.

50 Zack Cooper, Stephen Gibbons, Simon Jones, Alistair McGuire, *Does competition improve public hospitals' efficiency? Evidence from a quasi-experiment in the English National Health Service*, Centre for Economic Performance, London School of Economics and Political Science, February 2012.

Ultimately, there is no over-riding reason why a range of services, both surgical and medical, could not be provided by non-government public hospitals if these were to be established. But the obvious place to start is with elective surgery: it is here, as we have seen at the Alfred and elsewhere, that there are clearly demonstrated efficiency and equity advantages to be obtained by separation.

There are four possible basic models for separating elective from emergency surgery in Hobart and Launceston.

1. Establishing stand-alone facilities within the Royal Hobart and Launceston General hospitals.
2. Building separate elective-surgery hospitals on new sites.
3. Purchasing services and/or hiring facilities from private hospitals with spare capacity.
4. Dedicating discrete wards, and if possible entire existing buildings, within existing under-utilised private hospitals to form two new co-located public hospitals – one each in Hobart and Launceston – which will be able to share some capital equipment with their private neighbours.

The first would be the most administratively convenient but has the disadvantage that separate facilities would need to be established, at considerable expense and on constrained sites. More importantly, low- to moderate-acuity patients would not be removed from the competition from emergency and more urgent elective cases: mere administrative arrangements could quickly be set aside.

The second would be prohibitively expensive and would lack the advantages of co-location.

The third would make use of existing private facilities, bringing them within access of the public system, relieving pressure on the RHH and LGH, and potentially expanding the number of elective and emergency procedures available to public patients. But these would be comparatively difficult to administer as a facility with clear and meaningful separation both from the main public hospitals and the private hospitals that house them. It would be difficult to use private-practice surgeons and anaesthetists without paying them the much higher fees they can demand from their private patients. Increased demand for these doctors' services could be expected to inflate their prices further. This would be ameliorated to some extent by contracting with private hospital operators to provide the whole of a defined range and number of services, including paying the doctors. Or these facilities could be used by public hospital surgeons. But the problem would arise of having patients next to each other in a ward with similar or identical conditions, one of whom has paid for the service as a private patient when the other has been treated free. It would also be difficult to have two sets of doctors working alongside one another, doing the same job but being paid greatly different amounts. It would be rigorously opposed by the Australian Medical Association: history shows the AMA would have the power to derail or delay such a reform and to cost significant political capital for any government seeking to introduce it. A publicly funded facility doing a large share of elective surgery would have to undertake training of interns and registrars; this would add to the difficulties in which some surgeons would have teaching duties and their colleagues would not.

The fourth option – negotiating with a private owner to convert part of an existing operation into a discrete public elective surgery facility – is the most attractive. It would avoid the problems associated with the previous option while retaining its advantages. It would allow the RHH and LGH room to expand to meet increasing demand for medical care and non-elective surgery, and to achieve safer bed occupancy rates. In Tasmania, the most obvious partner is Calvary Healthcare. Hobart Private does not have the spare capacity. While the state's main public hospitals are operating at unsafe levels of bed occupancy, Calvary's problem is that it has too many empty beds, even though it has already closed large numbers through lack of demand. And for those beds still active it has a level of demand which is

uneconomically low. The AMA has given the proposal its initial in-principle support.

Calvary management has suggested that an initial 40-bed elective surgery ward could be built at its St John's campus in South Hobart for about \$5 million. Existing under-utilised theatre capacity would be used. The new ward would be divided mainly into four-bed rooms, with some single-bed rooms. At an average length-of-stay of three days, and an 85% occupancy, there would be a throughput of around 3600 patients a year. There would be no attempt to take over the entire elective surgery caseload of the Royal Hobart Hospital but the new facility would concentrate on low- to moderate-acuity patients – with procedures such as cataract extraction, endoscopies, gall bladder removal, gall and kidney stone removal, tonsillectomy and hip and knee replacement. More complex cases, including those which may need access to an intensive care unit, would remain where they are.

Because it has a far leaner administration, Calvary expects per-separation costs to be around 10% to 15% lower than the state presently pays in its major public hospitals. This would bring the new facility approximately into line with the national efficient price.

If the government was prepared to commit to a long-term (five years or more) or permanent arrangement, Calvary is likely to be prepared to contribute 30% to 50% of the initial capital cost, putting the government's share at around \$3 million. The state would be expected to contribute on a similar basis to necessary capital investment into the future, given that this is for the most part not covered within Casemix formulae. Further expansion of ward capacity in the new public facility would require additional theatres to be established.

In Launceston, the St Vincent's campus has three large areas capable of relatively easy and quick conversion to ward space and capacity to increase the number of theatres. The optimum size of any new public ward and increased number of theatres is still being evaluated by Calvary. It should be emphasised that this does not comprise an offer or commitment by Calvary: rather, it is an indication of what could be achieved if there was the political will to do it.

CONCLUSIONS

BY ANY reasonable measure, all major Australian public hospitals are under-funded. It is a result of rising costs, constantly increasing demand and – in a federation characterised by an unequal distribution of revenue between the states and the Commonwealth – the inability of cash-strapped states to pay for the hospitals they own and run. In the longer term, there will be no alternative to making the Commonwealth, which alone has the capacity to raise enough revenue to pay for an efficient health system, the sole funder of all the nation's public hospitals.

In the meantime, it is essential to use the money and resources we have to the best possible advantage. Failure to run our hospitals efficiently will mean inadequate funds will be even more inadequate. Patients who would be treated in an efficient system will not be treated. Sick people will needlessly stay sick and get sicker. They will develop avoidable complications which, when they inevitably end up in hospital, will cost more to treat. Some will die. The administrators, politicians and others who are responsible for the misuse of resources will seldom have to confront those whose lives and health are blighted by this unprofessional ineptitude and neglect: but those unfortunate and vulnerable people, nevertheless, will be there.

Tasmania does a worse job of running its hospitals than does any other jurisdiction in the country. As we have seen, the only reason for this that stands up to scrutiny is the failure of successive health ministers, hospital administrators and senior health bureaucrats to do their jobs properly. Other states manage it: so should Tasmania.

Running a hospital system is an undertaking of almost infinite complexity but, as this paper has shown, certain themes stand out. Our hospitals employ far too many clerks and administrators. Removing public servants is difficult but it must be done far more quickly and with far more determination than has so far been shown by the state government. Sacking staff is never easy, even when they should never have been employed in the first place, and the rules and agreements of the public service make it more expensive than for other staff. Nevertheless, our hospitals exist not to employ bureaucrats but to save lives and to make sick people well. Public servants who are not needed in a rigorously redesigned and streamlined administrative environment should be offered voluntary redundancy; those who remain who are no longer needed should be placed on the unattached list and, if they cannot be redeployed to other areas of the state service, should have their employment terminated.

It is becoming increasingly clear that the present system of block-funding hospitals is entrenching inefficient systems and allowing hospital staff and managements to defy ministers. When global budgets are set on the assumption that the money will be spent efficiently, hospitals have simply overspent, knowing that an opportunist Opposition and an ill-informed public will back them and that the government will have no choice but to retreat and bail them out.

There is a well-tried alternative. Casemix (or activity-based) funding gives hospitals not a fixed block of money (which may be moved from efficient services to prop up inefficient ones) but pays instead for each service – or 'separation' – the hospital provides. Each service has its own price, according to what it should cost in a reasonably efficient system: these are known as diagnosis-related groups (DRGs). Hospitals which provide a service for less than the casemix cost are allowed to keep the money; those which spend more have a strong incentive to reform their systems. Casemix has been in place in Victoria for some 20 years and in South Australia for almost that long. It is no coincidence that the two

states which have the best record of economic efficiency (see Table 1 on page 4 of this paper) are those in which casemix funding is in operation. The Commonwealth Department of Health and Ageing has been refining the system for some 30 years: it is a highly sophisticated process which has been proved in practice.

But to introduce national level of efficient pricing into Tasmania in the absence of determined systemic reform would invite chaos. A recently leaked document from the federal government's Independent Hospital Pricing Authority showed that, as plans stood at that time, Tasmania's hospital system would lose \$80 million a year in Commonwealth funds. The states and territories have secured an agreement that the funding of 'loser' states will be calculated at the old levels until 2019-20, thus negating the whole point of the exercise, which is to encourage and reward efficiency. Such a one-size-fits-all approach is not appropriate to a federation in which the various state systems start from such different stages of reform and levels of efficiency. Of all states, Tasmania would lose the most.

The DHHS administers a sophisticated system of casemix calculation but it is used as a guide to block-funding rather than as a direct method of funding hospitals. The values it uses are unrealistically and unsustainably generous: in fact, through being misused in this way, it is entrenching the very inefficiency it was designed to eliminate. Instead, direct casemix funding for the four major hospitals should be introduced over three years, with DRG weightings starting somewhat below those used by the DHHS at present and being reduced annually, in a predictable and transparent way, until reasonable levels of efficiency are attained. This should occur simultaneously with a comprehensive and determined process of systemic reform.

There is no shortage of ideas about how systems should be reformed. Over the past eight years there have been several inquiries and reports, including the Richardson report, the Tasmanian Health Plan, the National Health Reform process, the current federal commission led by Alan Bansenmer, a Legislative Council committee inquiry and report, and a list of efficiency reforms proposed by the Australian Nursing Federation. Some elements of some of these reports have been implemented but none has resulted in the thoroughgoing reform to efficiency and capacity that each has been intended to produce.

What needs to be done is well known. Why it is still not happening is much more obscure.

The political and administrative difficulty of these reforms should not be under-estimated, as it has often been in the past. These changes will require a government with substantial political capital and the willingness to spend a good deal of it on this goal. The government must have a firm and well-defined program, explain it to the people and seek their support, release all the relevant information so an informed and balanced discussion can take place, and pursue intensive reform for several years against strident opposition from vested interests, including some unions, administrators, politicians, certain doctors and others. The program of reform will be complex, easier to misrepresent than to explain. But other states have done it: surely, it cannot be beyond the wit of Tasmanians to do as well.

In the long term, any efficiency reform within the current funding strictures imposed on the states by the Australian federation will not be enough to produce a public hospital system of the standard, accessibility and responsiveness that the nation can afford and the people have the right to expect. For decades, the cost to states of public hospitals has risen about twice as fast as government receipts. That is why every hospital system in the country, even the most cost-efficient, stumbles unceasingly from one crisis to the next. Only the Commonwealth, which has the capacity to raise all the revenue it needs, can afford to run a modern health system. The states – for the most part – know how to run hospitals but cannot pay for them. The Commonwealth has no experience in hospital management but has the

cash. Until these roles are rationalised, with the Commonwealth taking single-funder responsibility for funding but with the states maintaining the day-to-day running of hospitals – albeit under overall Commonwealth supervision – the failure of our politicians to resolve an entirely avoidable calamity will continue to impose far too heavy a price in the lives and health of their electors.

ABOUT THE AUTHOR

Martyn Goddard is an independent health policy analyst based in Hobart. He has been a member of several key Commonwealth committees, including the peak ministerial advisory group on AIDS and hepatitis, and was the first consumer member of the Pharmaceutical Benefits Advisory Committee, which evaluates drugs for listing on the PBS. He has conducted many policy reviews and submissions for Commonwealth and other organisations, and is a former health policy spokesman for the Australian Consumers' Association. Before becoming involved in health, he was a journalist and documentary producer, mainly at the ABC in Sydney and Melbourne.

This paper has not been funded or in any way controlled by any person or organisation other than the author.