Saving health

Why a Commonwealth takeover of Tasmania's health system is needed and how it could work

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Executive summary

Tasmania's health system is on the brink of collapse. The causes and the solutions go far beyond the present budget cuts and are best illustrated by one simple set of figures. In the ten years from 2000-01 to 2009-10, the amount spent by the state government on public hospitals rose, year-on-year, by an average of 11%. For the same period, spending on everything other than health rose year-on-year by an average of only 5.7% a year and total government revenue by 6.1%. *(page 11)*

No state or territory government, in Tasmania or anywhere around the nation, can manage for ever the relentless budget pressure of health unless its income rises by just as much. Tasmania's situation is fundamentally no different from that of the other states, particularly the non-mining states with weak economies being damaged by the high dollar and low consumer spending. Tasmania has got there first but others are not far behind.

A new structure

This paper contends that the present split of funding responsibilities between the states and the Commonwealth does not work and is not likely to work; and that the health and hospitals system will not function effectively until responsibility is removed from the states, which cannot afford to pay, to the Commonwealth, which can.

A new, Commonwealth-funded structure for Tasmanian health services must:

- Keep day-to-day administration located in Tasmania: the Commonwealth Department of Health and Ageing has no history of performing these practical functions and cannot do so;
- Maintain health employees in the state industrial relations and superannuation systems: they and their unions would block any move to put them into the federal systems;
- Ensure the Commonwealth has enough sense of ownership and political responsibility to give it no option but to fund and nurture the system properly;
- Attract the support of the major stakeholders.

The solution proposed in this paper involves establishing a single funding stream, with the Commonwealth both as the sole funder and as the owner of the physical assets presently owned by the state. The Commonwealth would purchase health, hospital and administrative services from agencies staffed by Tasmanian state employees. The state would surrender a proportion of GST equal to the amount it has historically spent on health. Despite the various legal and functional complexities, this structure will be relatively straightforward in terms of its practical operation. The details are given in the first chapter of the main section of this paper, and will not be repeated here. *(page 8)*

Salvation will not come in the form of special payments from the Commonwealth. Unless these amounts are given to all states and territories in line with their assessed GST entitlements, the Commonwealth Grants Commission will deduct any money that it deems to upset existing relativities between the states. Tasmania presently receives 3.5% of the national GST pool; if it is

given more than 3.5% of any Commonwealth specific-purpose payment program, that money will be taken back by the Grants Commission in the form of lower general GST payments. In the long run the state would be worse off because it would have had the right to spend GST money as it wishes; the specific purpose money from the Commonwealth comes with many conditions and can only be spent in ways the Commonwealth stipulates and involves significant compliance costs. *(page 13)*

Demographic realities

On average, Tasmanians are older, poorer and sicker than their fellow Australians. They are therefore more likely to need health interventions and less able to pay for it themselves. Death rates are higher, life expectancy shorter, and wages lower. Tasmania has more children in one-parent families, lower labour force participation, more smokers, more obesity, older average ages and more avoidable deaths than the national average. *(page 18)*

A constant state of crisis

When hospitals are underfunded for decades, as Tasmania's have been, the system becomes not only unable to cope with its sick and vulnerable population but its economic and clinical efficiency plummets. An inadequate system will focus increasingly on the most seriously ill people, starting with those who will die without immediate care. Less urgent cases are neglected, even though this neglect may result in expensive, dangerous and distressing complications. Earlier intervention, which is almost always cheaper than later emergency treatment, is no longer possible.

Tasmania's two major hospitals operate constantly with bed occupancy rates well in excess of those generally considered safe. In mid-2011 average occupancy rates at the Royal Hobart Hospital stood at 98% and at the Launceston General at 97%. This indicates substantial periods in excess of 100% and almost no capacity at all to cope with surges in demand. The usually quoted safe occupancy figure is around 85%.

The result is increased levels of infection, more mistakes by overworked staff and poorer treatment outcomes for a variety of conditions. It also causes patients to be backed up in emergency departments, a situation known as access block or bed block. This adds immensely to the workload of ED staff and costs more than being accommodated on a ward. It is also associated with a higher death rate: people affected by bed block are 20% to 30% more likely to die. In Tasmania, this is likely to account for 90 to 100 avoidable deaths annually, three times the road toll.

The resultant overcrowding in emergency departments leads to patients being unable to be discharged from ambulances, a situation known as ambulance ramping. This is also likely to have a cost in mortality and disease complication but the most easily documented result is that ramped ambulances are unable to respond to new calls. To maintain response times, more ambulances must be bought and more paramedics employed at a considerable and avoidable cost to the health budget.

Bed occupancy rates are unsatisfactorily high not mainly because insufficient public acute beds exist – there are just as many *per capita* in Tasmania as in other states – but because there are too few cheaper, more patient-friendly alternatives to acute inpatient care. But these cheaper alternatives cannot be afforded partly because so much money is spent on a system unduly focussed on acute care, whether or not that style of care is best for the patient. Developing alternatives will cost money the state does not have. (*page 21)*

Elective surgery

Even before the recent astonishing cuts to elective surgery, public hospitals have been forced for decades to concentrate on emergency and life-saving treatment while neglecting those surgical patients whose procedures can be delayed. Waiting times are far greater than anywhere else in Australia, and now will quickly get much worse. Some patients will suffer serious and occasionally fatal complications as a result of these delays.

Waiting times for a first consultation with a surgeon – the waiting list to get on the waiting list – are often even longer. At the Royal Hobart Hospital, surgery clinic waiting times range up to two and a half years.

Although elective surgery waiting times and bed occupancy rates in the major public hospitals are unsafe and seriously unsatisfactory, beds in private hospitals – which account for almost half the acute beds in the state – are seriously under-utilised. A possible scheme for cost-effective and non-inflationary direct government funding of these facilities is outlined in the final chapter of this paper. *(page 28)*

Saving the system

It is the contention of this paper that no present or future Tasmanian government, regardless of party, will be able to afford to run the state's public health and hospital system. The specifics of this rapidly worsening health funding situation will be documented elsewhere in this paper. But because so many people rely on the system for their health and survival, its approaching failure represents potentially one of the greatest and most damaging crises in Tasmania's history.

The cuts already being made will not be the last. The Tasmanian government is taking $100 million, or about eight per cent, from its health budget in the current financial year. This will increase to $500 million over the course of the four-year forward estimates period. The cuts are already eviscerating not only elective surgery, but – in a less publicised way – non-elective services as well. Unless the state can gain an income stream which not only rises in line with health costs but also allows it to make up for decades of under-spending, Tasmania's health system will become rapidly less able to treat those whose health and lives depend upon it. Already, the ideal of a universal health system, which treats people according to their need and not according to their personal wealth, is becoming a distant dream. As the system implodes, not only individuals will suffer. The costs will also be in productivity across the state's economy – sick people do not produce – and in social cohesion, as people who cannot receive needed and sometimes life-saving treatment look across suburban boundaries at those who can afford to pay for it themselves. Because these realities will face any party holding power, there will be a comprehensive loss of faith in the capacity and willingness of governments, state and federal, to perform their most crucial functions.

Ever since 1946, the Commonwealth has had constitutional power to enact laws on health and health funding. Over the years it has taken an increasing role in this area, as the relative capacity of the national government to raise money increased, and the states became increasingly poorer. The Pharmaceutical Benefits Scheme, Medicare and the National Immunisation Program are international standard-bearers for economically efficient and humane financial interventions in what had previously been none of the Commonwealth's business. The Whitlam government in 1975 introduced funding to enable public hospitals to accept all patients free of charge, a facility which had previously been available only in Queensland. But since then the Federation has failed to maintain adequately the key state-based elements of its health system – almost all the nation's 756 public hospitals, much of its disease prevention effort, ambulance, public dental services, mental health, sexual health and community-based primary care clinics – in a sustainable manner.

In 2010 the Commonwealth Treasury estimated that, on current trends, health spending alone would equal the whole of Australian state government receipts by 2044-45, and that this would happen sooner in some states.[1] And that is on the basis of what is actually spent, not what ought to be spent to meet demand. In other words, if the present funding trends continued, there would be no money left for schools, roads, police, national parks, tourism or any other state government responsibility. That would, of course, not happen. A more likely scenario is that all state government services would become increasingly inadequate and would face rolling functional crises which would exact unbearable political damage on successive governments and increasing public contempt for the processes of government. In health, the cost would be measured in lives.

1. Department of Health and Aged Care (DoHA), *A national health and hospitals network for Australia's future,* DoHA, Canberra 2010, p. 49.

Historically, health spending by Australian states has increased at about twice the rate of other areas of state responsibility. Therefore, removing health from the states' budgets would put the rest of their services onto a far more manageable financial footing.

There are two possible answers to the funding crisis in health. One is to rely on the Federation to work as it should, which would involve the Commonwealth bearing a much larger and more rapidly increasing share of state health costs than it has ever done before. Eventually, the Commonwealth would foot almost the entire bill, but would still have little practical or direct control over how its money was spent – an unhappy situation for any government.

Before the 2007 election, Kevin Rudd called for a Commonwealth takeover of Australian state-based health and hospital systems, saying that if the states were unwilling to cooperate in this, he would seek to change the Constitution at a referendum. On becoming Prime Minister, Mr Rudd instead appointed large-scale policy reviews and conducted exhaustive consultations with hospital staff and many others. In 2010 the government offered to become the dominant funder of state health services, providing 60% of recurrent and capital spending, and taking over full responsibility for primary care. A number of structural reforms were proposed, most importantly the introduction of activity-based (Casemix) funding to those states which did not already have it. In return, the states were to surrender a proportion of their receipts from the Goods and Services Tax.[2]

The Tasmanian government enthusiastically endorsed these proposals but the agreement of the major states foundered on the GST issue. Eventually the Gillard government introduced its current policy, which is in the implementation stage. The Commonwealth has promised to fund 45% of the growth in the cost of hospital services, rising to 50% by 2017.[3] There is no new commitment for capital expenditure, which has suffered from decades of under-investment by successive cash-strapped Tasmanian governments. Under a separate agreement, a number of special-purpose programs aimed at elective surgery, emergency and sub-acute beds will run in the meantime. The maximum amount Tasmania can expect from this is $89.2 million spread over eight years – averaging $11.5 million a year.[4] That is welcome, but the state government is now attempting to take over $100 million a year out of its health system to meet its ongoing funding crisis caused, largely, by health costs it cannot afford. There is much good and rational policy in the Commonwealth reforms, but as investment they are far too little and far too late to save the Tasmanian system. By 2017, the system will have reached a state of collapse.

A central drawback of any system requiring fixed percentage contributions from state and federal governments is that the state's capacity to meet its share would automatically define (and reduce) the amount the Commonwealth put in. Effectively, this would be a matched-funding arrangement, with all the limitations of such a scheme. Both the Rudd and Gillard plans also fail to address one of the most significant reasons for the decline of the public health and hospitals system: the historical inability of the state to fund adequate capital investment. Our hospitals and other infrastructure need massive upgrading and, in many cases, replacement. Meeting that immense need would require a very large initial investment. The Tasmanian government is in no position to fund any substantial share of that amount.

The federal Coalition policy promises substantial funding, including $2.3 billion nationally over four years for 2800 extra public hospital beds; but if Tasmania receives more than 3.5% of this

2. *Ibid.*
3. Council of Australian Governments, *National Health Reform Agreement,* COAG, Canberra 2011.
4. Council of Australian Governments, *The National Health Reform Agreement – National Partnership Agreement on Improving Public Hospitals*, COAG, Canberra 2011.

money – the same as its GST share – the extra money will be lost in the process of GST equalisation by the Commonwealth Grants Commission. The Coalition also wants to devolve hospital governance even further than under the present reforms, re-establishing governing boards for individual hospitals and giving them administrative responsibility. The policy does not explain how this would avoid a vast increase in bureaucrat numbers or how it would prevent the further fragmentation of a system desperately in need of coordination.[5]

In the 65 years since Canberra gained constitutional responsibility for health, no Australian state government has been prepared to relinquish its health powers and no Commonwealth government has been prepared to assume them. But in this crucial area, the Federation as it stands is not delivering the services the Australian people want and deserve. The partial and *ad hoc* schemes – including one-off special purpose grants and other time-limited commitments – favoured by both major parties will not save Tasmania's health system. It is time for reform.

In Tasmania's case, the matter is urgent. Under the present arrangements, the state's health system is on the brink of collapse and will be unrecognisable as a universal health care system within perhaps five years. Because of the funding pressures presented by health other areas of state responsibility, including education, police and roads, will also face deep and continuing threat. If Tasmania is to continue to exist as a separate and successful polity, the responsibility for incurring the health system's bills will have to devolve to the only level of government capable of paying them.

This paper proposes a framework for the transfer of state health services designed to overcome many of the problems which could beset such a process. In particular, it addresses concerns about the capacities of the Commonwealth Department of Health and Ageing in the practical administration of hospitals, and the future of Tasmanian public employees working in health.

For these major changes to go ahead, they must occur within a framework which has the general support of all key stakeholders – consumers; employees including doctors, nurses, paramedics, public servants and others; state and federal governments; and, if possible, the major political parties. For health unions, transfer of their members to the Commonwealth industrial relations and superannuation systems would be a deal-breaker. Without their agreement, substantial reform of Tasmania's health system is unlikely to occur. Therefore, a solution must be found which will allow the Commonwealth to assume ownership, control and responsibility for the system while allowing Tasmanian employees currently covered by the state industrial relations system and the State Retirement Benefit Fund Contribution Scheme to remain in those regimes.

The unions oppose transfer to a Commonwealth industrial relations environment both because they believe collective bargaining is more difficult under the federal system and because some Tasmanian hospital employees, including doctors, nurses and paramedics, have been able to secure better pay and conditions than is usual among their mainland counterparts. The unions' justification for this is that these extra benefits are necessary in order to attract and keep highly qualified people into a small hospital system which has a reputation for being less well equipped than its peers.

This should not compromise economic efficiency relative to other jurisdictions. Despite the Tasmanian health unions' claims of having secured higher wages, public hospital employees in Tasmania are among the least well-paid in the nation.[6]

5. Liberal Party of Australia, *The coalition's plan for real action on hospitals and nursing,* Canberra 2011, www.liberal.org.au (accessed 21/09/2011).
6. Australian Institute of Health and Welfare, *Australian Hospital Statistics, 2009-10,* AIHW, Canberra 2011.

Table 1: Average full-time equivalent salaries, public acute and psychiatric hospitals, 2009-10

Average salaries	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Salaried doctors	147 133	165 958	186 325	198 745	169 945	**151 707**	159 013	195 572	**168 026**
Nurses	81 078	81 210	85 976	83 484	76 596	**79 273**	81 878	96 654	**81 974**
Diagnostic, allied	69 099	54 878	99 989	80 619	80 485	**84 501**	78 095	85 922	**69 996**
Administrative	64 665	48 173	63 012	66 560	53 632	**57 416**	63 833	64 376	**58 737**
Domestic, other	60 365	64 857	52 266	56 162	35 611	**48 367**	53 424	56 829	**56 978**
All staff	**82 213**	**78 564**	**92 300**	**90 167**	**80 221**	**81 579**	**87 228**	**95 161**	**83 922**

Source: AIHW

A new administrative structure

Any new arrangements will need to satisfy several requirements. They must:

- Keep day-to-day administration and asset allocation decisions in Tasmania, where the people making these decisions are close to those who will have to deal with the results.
- Maintain health employees in the Tasmanian industrial relations system.
- Ensure the Commonwealth has a real sense of ownership and control over the system – enough 'skin in the game' to give it the incentive to fund and nurture the Tasmanian health and hospital system as it deserves.
- Attract the broad support of all major stakeholders.
- Be practical and legally compliant.

The structure which best meets these requirements involves dual delegated lines of responsibility – to the state for the employment of staff and to the Commonwealth for the spending of money. It involves:

- Appointment by the Commonwealth government of a second Parliamentary Secretary for Health to oversee the Commonwealth's interests in Tasmania.
- A new Health and Hospitals Purchasing Authority would be established under Commonwealth law and would be responsible for buying services from the Tasmanian Health Organisations (the new name for the Local Hospital Networks established under the Commonwealth's health reform agreement), health NGOs and others, under the sorts of service agreements currently signed by the DHHS. The authority would have no or minimal staff of its own. Any staff of its own would be Commonwealth employees and would be covered by the Commonwealth industrial relations and superannuation systems.
- The authority's CEO would also be the CEO of the health elements of the DHHS; these elements would be spun off from the present Department and become a separate agency. This new administrative agency would operate under a service agreement to supply the central authority with administrative services. The two would be co-located.

- The joint CEO would sign two employment contracts: one with the Commonwealth, the other from Tasmania. He or she would receive delegated power from the Premier to direct staff (under the State Service Act) and from the Parliamentary Secretary via the Purchasing Authority to spend money. This person would be the point at which delegated powers from Tasmania and the Commonwealth intersect.

- The Premier would be responsible to the Tasmanian Parliament for those elements still covered by the state system, principally the employment and conditions of staff.

- The Parliamentary Secretary would be responsible to the Commonwealth Minister for Health and the Australian Parliament for the expenditure of Commonwealth funds and the overall state of the Tasmanian publicly-funded health and hospital system.

- The THOs and the other elements of the existing national reform program would remain in place. The new system would build on that.

Transfer of physical assets

Health infrastructure owned by Tasmania, including public hospitals and their equipment, mental health infrastructure, dental clinics, vehicle fleets and outpatient services, should be transferred to the Commonwealth at no cost either way, or at a nominal sale price. Although conventional accountancy rules would specify that this infrastructure is a concrete asset with a monetary value, in practical and political terms these facilities represent a liability just as much as they represent an asset. Because their services are mostly delivered to patients free of charge, no monetary return on assets could reasonably be expected unless they were sold to a private operator – assuming, of course, that a willing buyer could ever be found. The return on these assets certainly exists but it is measured in social, not commercial, terms. Tasmania's hospitals and other state health services have been underfunded for decades and require very large capital and recurrent investment to bring them up to an economically and clinically efficient standard.

GST transfer

A proportion of revenues equal to the amount historically used by the state to fund health services should be surrendered to the Commonwealth. The state receives two major streams of transfers from the Commonwealth: its share of the Goods and Services Tax; and specific purpose payments (SPPs) for health, comprising the National Healthcare SPP and those National Partnership Payments intended for various health purposes. The health-specific payments would automatically be surrendered with a transfer of health funding responsibility. On top of this, a proportion of the state's GST entitlement would also have to be surrendered. If this was calculated on the basis of 2010-11 budget figures, 27.6% of Tasmania's GST entitlement would be ceded to the Commonwealth. This change in Commonwealth-state relations would also create the opportunity for the two governments to have a conversation about some of the remaining state taxes and changes, most of which either suppress the economy (payroll), cost a disproportionate amount to collect (stamp duty) or have unpleasant social costs (gaming).

Primary care

Primary care, consisting largely but not exclusively of GP services, is overwhelmingly the province of the Commonwealth. Generally, services are funded by a combination of Medicare rebates and

patient co-payments. But the state controls a variety of primary care services, including community clinics, children's and adults' public dental clinics, various non-inpatient mental health services and a state-wide sexual health service. Where the state owns the infrastructure for these services, it should be transferred to the Commonwealth's formal ownership. Funding responsibility for non-government organisations providing these services should also move to the Commonwealth and be administered by the new purchasing authority.

Recent reforms

Recent national reforms to the structure of public hospital and other services would remain in place. These include Local Hospital Networks, Medicare Locals and various advisory groups, activity-based (Casemix) funding and the independent funding body. Complex state-based elements of funding administration could be discontinued and the system returned to the Commonwealth's much simpler and more efficient original proposal.

Population (public) health

Responsibility for disease prevention is shared by programs controlled by the states and by the Commonwealth. Many state programs already receive special purpose grants from the Commonwealth; some are contracted to non-government organisations. The processes for funding public health are complex and sometimes lack long-term certainty. The Population Health section of the present DHHS would supply services to the Purchasing Authority through the service agreement between the Authority and the new administrative agency (formerly the health elements of the DHHS). There may be a case for maintaining some elements with a close connection to local government, such as environmental health, within the state system. If that occurs, special arrangements would have to be made.

Ambulance

The formal ownership of the fleet and infrastructure of Ambulance Tasmania would be transferred to the Commonwealth. As an agency, it would supply services to the Purchasing Authority according to a service agreement.

Forensic medicine

Forensic services currently administered by the DHHS would be transferred to the Police Department. Existing agreements for access to public hospital and other health facilities should continue to by honoured under the new administration.

Financial realities

A dominating reality of all state and territory government funding has been the rate at which health expenditure has increased, compared with all other areas of spending and compared with revenue. In Tasmania over the ten years between 2000-01 and 2009-10, the state's share of funding for acute health (public hospitals) rose by an average of 11% a year.

The government's overall expenditure, on all state activities, grew on an average of only 6.5% and non-health expenditure by 5.7%. Hospital costs rose at almost twice the rate of all government activities outside of health.

Table 2: Tasmanian government spending and revenue, financial years ending 2001 to 2010

		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Av %
Acute care	$ million	367	366	370	399	422	570	715	652	799	885	
	% change		-0.3	1.1	7.8	5.8	35.1	25.4	-8.8	22.5	10.8	**11.0**
Total health	$ million	552	570	583	649	723	890	944	964	1 101	1 212	
	% change		3.3	2.3	11.3	11.4	23.1	6.1	2.1	14.2	10.1	**9.3**
Non-health	$ million	2 048	2139	2 228	2 344	2 507	2 669	2 746	2 984	3 263	3 372	
	% change		4.4	4.2	5.2	7.0	6.5	2.9	8.7	9.3	3.3	**5.7**
Total gov exp	$ million	2 600	2 709	2 811	2 993	3 230	3 559	3 690	3 948	4 364	4 584	
	% change		4.2	3.8	6.5	7.9	10.2	3.7	7.0	10.5	5.0	**6.5**
Total revenue	$ million	2 702	2 853	2 980	3 237	3 385	3 577	3 695	3 986	4 286	4 602	
	% change		5.6	4.5	8.6	4.6	5.7	3.3	7.9	7.5	7.4	**6.1**

Source: ABS

If this trend continued expenditure on health would eventually account for almost the entire budget. That extreme stage is some way off and is perhaps less pressing than some government statements claim. Nevertheless, the state's capacity to pay for its health system became unsustainable some time ago and appears now to have entered a phase of rolling crises.

Table 3: Health expenses as a percentage of total government revenue, financial years ending 2001 to 2010

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
20.4	20.0	19.6	20.0	21.4	24.9	25.5	24.2	25.7	26.3

Under successive governments, health spending has tended to follow decade-long cycles of stringency and cuts followed by attempts to catch up. Because of this extreme volatility, and the lesser but still significant volatility of total revenues, any meaningful projections must be based on known averages drawn from periods of no less than ten years. Using the average year-on-year changes for the period 2000-01 to 2009-10 to project forward to 2030, it can be seen that (all else being equal) Tasmanian government health costs would rise to 47.7% of total revenue by the end of the period. This is not as dramatic as the total swamping of the budget by 2025, as predicted by the government,[7] but it is serious enough. The state budget would go immediately into long-term deficit; that deficit would have to be funded with borrowings, which would incur compounding

7. Michelle O'Byrne, 'Notice of motion', *Notice Paper*, Parliament of Tasmania, Hobart 18 October 2011.

interest as they were carried over from one year's budget into the next. Assuming a steady interest rate throughout the period of 5% *per annum*, the state would incur a deficit of $1.44 billion by 2020 and $10.84 billion by 2030.

Table 4: Projection of Tasmanian government expenses and revenue, financial years ending 2011 to 2030 (millions)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Acute care	982	1 090	1 210	1 343	1 491	1 655	1 837	2 040	2 264	2 513
Total health	1 325	1 448	1 583	1 730	1 891	2 066	2 259	2 469	2 698	2 949
Non health	3 557	3 751	3 955	4 167	4 390	4 622	4 865	5 118	5 381	5 656
Total expenses	4 882	5 199	5 537	5 897	6 280	6 689	7 123	7 587	8 080	8 605
Total revenue	4 883	5 181	5 497	5 832	6 188	6 565	6 966	7 390	7 841	8 320
Surplus/deficit	1	-18	-40	-65	-92	-124	-157	-197	-239	-285
Cumulative def.		-17	-57	-122	-214	-338	-495	-692	-931	-1 216
Incl 5% interest		-18	-61	-132	-235	-377	-561	-796	-1 087	-1 440
	2021	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Acute care	2 789	3 096	3 437	3 815	4 234	4 700	5 217	5 791	6 428	7 135
Total health	3 223	3 523	3 851	4 209	4 601	5 028	5 496	6 007	6 566	7 176
Non health	5 941	6 237	6 543	6 861	7 189	7 527	7 876	8 234	8 601	8 976
Total expenses	9 164	9 760	10 394	11 070	11 789	12 556	13 372	14 241	15 167	16 152
Total revenue	8 827	9 366	9 937	10 543	11 186	11 868	12 592	13 361	14 176	15 040
Surplus (deficit)	-337	-394	-457	-527	-603	-688	-780	-880	-991	-1 112
Cumulative def.	-1 553	-1 947	-2 404	-2 931	-3 534	-4 222	-5 002	-5 882	-6 873	-7 985
Incl 5% interest	-1 866	-2 373	-2 972	-3 674	-4 490	-5 437	-6 528	-7 779	-9 208	-10 836

Table 5: Health expenses as a percentage of total government revenue, financial years ending 2011 to 2030

2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
27.1	27.9	28.8	29.7	30.6	31.5	32.4	33.4	34.4	35.4
2021	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
36.5	37.6	38.8	39.9	41.1	42.4	43.6	45.0	46.3	47.7

This is not a forecast and does not pretend to be: there are too many unknown variables. It does not take into account short-term variations, such as the present dip in GST revenues and the cuts to health and other state government services, nor the mild but real increases in health costs as a result of population ageing. But, assuming there is not another global financial crisis and that both revenue and expenditure eventually revert to their long-term averages, it may not be very far from reality. Nonetheless, it provides a baseline upon which various other, more complex, scenarios may be constructed.

Few of the probable variations would improve the state's financial position: just the opposite. But even under the projections above, the inexorable rise in health cost and demand for hospital services will push the budget into an ever-increasing deficit from the current financial year forward. The only defence – apart from surrendering health responsibilities to the Commonwealth or securing, somehow, a more viable revenue stream – will be to make savings in administration and to cut services further and further every year.

Specific purpose payments

Salvation will not be found in one-off special payments from the Commonwealth. These payments are not well understood; nor is the fact that, in almost all cases, money received in such programs must be paid back in terms of commensurately lower GST receipts. A state receiving this money has, in effect, its wages docked for the same amount by the Commonwealth Grants Commission. The reason for this is to be found in a key Commonwealth Grants Commission policy called horizontal fiscal equalisation. This is the policy under which the Commission tries to even up the differences between rich and poor states, by giving some (such as Tasmania) a larger *per-capita* share of GST than others (such as Western Australia). The equalisation policy recognises that some states are more able to raise money of their own – such as through mining royalties – than others. GST relativities are calculated so that all states, provided they operate with equal efficiency, are theoretically able to deliver roughly the same levels of service to their people.

The Commission's rules specify that most payments to a state made as Specific Purpose Payments or under National Partnership arrangements affect that state's capacity to provide services, and put it ahead of the others, upsetting the balance.[8] So the Commission restores the balance by reducing that state's GST entitlement on a dollar-for-dollar basis: that state loses all of the money it has received in excess of its GST entitlement ratio. This money is clawed back over a three-year period, one-third in each year. This money then goes into the general GST pool and is redistributed to all states according to their GST entitlement ratios. As this table of relativities shows, of every $1 million originally intended for Tasmania, NSW would get $309,000, Victoria $225,000 and Queensland $190,000. Tasmania would get $36,000.[9]

Table 6: State and territory percentage shares of GST, 2011-12

NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
30.9	22.5	19.0	7.5	9.3	3.6	1.8	5.6

Source: Commonwealth Grants Commission

When Specific Purpose Payments are made to all states and territories in line with their GST entitlements, there is little or no need for equalisation by the Grants Commission. Even in this case, though, they represent a major source of administrative and fiscal inefficiency. They lock the states into a particular pattern of spending which may not be of its own choosing. Money involved in these payments, including contributions demanded from the states, cannot then be used for other purposes as the need arises. And the stiff conditions and reporting requirements imposed by these agreements involve a significant extra cost in administrative red tape. Access Economics has estimated the higher-than-necessary costs of government and the harm to economic efficiency involved with these payments at $9 billion a year.[10]

The problem is not a small one. Specific purpose payments represent about 40% of all Commonwealth transfers to the states and territories.[11] The 2011-12 Commonwealth budget put

8. Council of Australian Governments, *Intergovernmental agreement on federal financial relations: Schedule D: Payment arrangements,* COAG, December 2008.
9. Commonwealth Grants Commission, *Report on state revenue sharing relativities: 2011 update,* (media release) CGC, Canberra February 2011.
10. Access Economics, 'The costs of federalism' in Business Council of Australia, *Reshaping Australia's federation, A new contract for federal-state relations,* Canberra 2006.
11. Scott Bennett, Richard Webb, *Specific purpose payments and the Australian federal system,* Research paper, Parliamentary Library, Parliament of Australia, Canberra January 2008.

aside $45.5 billion for these payments, a total of 12.4% of all Commonwealth expenditure for the year. Of this, $15.381 billion was to go to health and $13.644 billion to education.[12]

Spending patterns

Per capita overall recurrent health spending from all sources (federal, state, private insurance, individuals) on all programs (hospitals, PBS, Medicare, private hospitals, doctor visits, etc) in Tasmania is similar to that in other states. In 2008-09, $4936 was spent per person, almost exactly the same as the national average of $4928.

Funding of public hospital services presents a different picture. The Commonwealth funds public hospitals through overall agreements with the states, through the Department of Veterans' Affairs and through the share of the rebate on private health insurance premiums that end up in public hospitals when they treat private patients. In all other states, the Commonwealth's total contribution is less than that of the state government; in Tasmania, it is slightly more. Even the two territories put considerably less reliance on Commonwealth money.[13]

Table 7: Shares of funding (recurrent and capital) of public hospital services by source of funds 2008-09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
C'wlth	36.8	39.9	36.8	36.5	38.9	46.7	28.9	32.3
State/terr	52.2	49.6	57.7	56.8	56.2	45.5	68.8	64.9
Non-govt	9.2	10.5	5.5	6.7	4.9	7.8	2.3	2.8

Source: AIHW

Spending on capital investment – buildings, medical and surgical equipment, furnishings, computers and so on – is best measured by how the rate of new investment compares with the rate of depreciation, or capital consumption. The results tell us whether we are using up fixed capital more quickly than we are replacing it, or vice-versa. The figures do not, of course, measure those new things that *should* be bought but are not, for instance the equipment used in new medical and surgical techniques; nor do they measure unmet need for new beds and services caused by rising numbers of patients.

Tasmania's record in this area is worse, and more volatile, than any other state and better only than the Northern Territory's, where distance and a large indigenous population make it a special case. Between 1999-2000 and 2002-03, Tasmania was using up more capital than it was replacing. The state then tried to catch up, but its capital spending for the decade still remained below that of other states. In the following table, a figure less than 1 indicates that capital is being used up more quickly than it is being replaced; above 1 means the opposite.[14]

12. Australian Treasury, *Commonwealth budget 2011-12: Budget paper no. 3, (Payments for specific purposes),* pp. 19-20, Treasury, Canberra 2011.
13. AIHW, *Health expenditure Australia 2008-09,* AIHW, Canberra 2010, pp. 56-60.
14. AIHW, *ibid.,* p.82.

Table 8: Government capital expenditure as a proportion of government capital depreciation 1999-2000 to 2008-09

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1999-00	0.94	1.65	2.22	1.31	1.45	**0.48**	0.94	0.38	**1.47**
2000-01	1.25	1.57	2.13	1.53	1.32	**0.52**	1.53	0.37	**1.53**
2001-02	1.49	1.85	1.85	1.44	1.51	**0.94**	1.91	0.32	**1.59**
2002-03	1.45	3.02	1.03	1.43	1.80	**0.51**	1.20	0.61	**1.65**
2003-04	1.14	1.00	1.06	1.78	1.72	**1.24**	1.51	0.73	**1.17**
2004-05	1.25	1.63	1.27	2.22	2.09	**1.67**	1.86	0.89	**1.49**
2005-06	1.48	2.09	1.35	1.90	1.61	**1.63**	2.08	0.72	**1.62**
2006-07	1.20	2.64	1.56	1.76	0.50	**1.70**	1.26	0.89	**1.60**
2007-08	1.42	0.99	1.97	2.80	1.18	**1.51**	1.88	0.62	**1.51**
2008-09	1.46	1.45	2.49	3.74	1.92	**1.21**	2.76	0.97	**1.90**

Source: AIHW

Tasmania also spends a lower proportion of its health budget on health research and development than any other state; only the Northern Territory's is lower.

Can Australia afford health care?

It would take something far bigger than the Tasmanian health system to push any Australian government into financial difficulty. A more serious question is whether, if more states followed the path proposed for Tasmania, the Commonwealth would be able to afford the long-term increase in health costs, particularly those of an ageing society. In other words, would we just be putting off the inevitable?

The answer is almost certainly no. Long-term projections for health care costs are unlikely to turn out to be very accurate – there are too many variables – but this does not mean we cannot reach a realistic view about what is most likely to happen.

National health price inflation over the past decade has been benign. The total health price index has been moving less quickly than national economic growth and general inflation (as measured by the ABS implicit price deflator for GDP) throughout most of the period. In the ten years to 2008-09, health price inflation has been less than general inflation in seven.[15] Price inflation measures the cost, essentially, of those items or kinds of items already in use: it does not include innovative technology, higher staff numbers or increased numbers of people seeking care.

15. AIHW, *ibid.,* pp. 12-13.

Table 9: Annual rates of health inflation, 1999-2000 to 2008-09 (%)

Fin year	Health inflation	General inflation	Excess health infl.
2000	2.2	2.6	-0.3
2001	3.7	4.7	-1.0
2002	3.2	3.1	0.0
2003	3.2	2.7	0.5
2004	3.4	3.3	0.1
2005	3.7	4.1	-0.4
2006	4.0	4.9	-0.8
2007	3.5	5.1	-1.6
2008	2.3	4.4	-2.0
2009	2.9	4.9	-1.9

Source: AIHW

Myths abound. There is, perhaps, more nonsense talked about the effect of ageing on 'soaring' health care costs than about any other aspect of health financing. Superficially, it seems a logical and appealing argument: people over 65 cost more in health care; as the postwar baby-boomer generation ages, we will have more people in that age bracket; therefore, health costs will increase by as much as the population ages. But various detailed models by health economists, using different methods, come to the same unexpected conclusion.[16,17,18,19,20] The cost of health care between now and mid-century that is attributable to ageing will be minor and manageable. Overall, the models say, ageing-related health costs will be greatly exceeded by the nation's capacity to pay, measured by the growth in gross domestic product.

There are many keys to this apparent illogicality. The main one is that age-related health costs are best measured not by how old a person is but how long it will be before he or she dies. For instance, as much as 40% of lifetime health costs accrue in the last two years of life.[21] This is known as the Fuchs effect, after the health economist who described it thirty years ago. When the relevant effects are allowed for, the reason for such fear about the health costs of an ageing population disappear. There will be an increased demand for some services – such as cataract excision and hip replacement – but this will not be enough to constitute a major cost element. Cooper and Hagen calculated that the annual rate of rise in overall Australian hospital costs would peak at 1.8% in 2012 and decline gradually to about 0.5% by 2051. Richardson and Robertson concluded that 'the impact of future ageing on the need for medical services will be so small that, in the absence of other factors, the size of the health sector would diminish in relation to GDP'.

Other factors in future health cost inflation are harder to predict. Attempts to do so can easily stray into the realm of the fairground fortune-teller. Historically, the main drivers of health expenditure have been labour and provider costs, new technology, pharmaceuticals and increased use of existing therapies. Another is found in the tendency of increasing demand for health services to respond to

16. Jeff Richardson, *Ageing and health care: Inexorable costs versus modest adaptation,* Centre for Health Economics, Monash University, Melbourne 2004.
17. Jeff Richardson, Iain Robertson, *Ageing and the cost of health services,* Centre for Health Program Evaluation, Monash University, Melbourne 1999.
18. C Cooper, P Hagan, *The ageing Australian population and future health costs: 1996-2051,* Department of Health and Aged Care, Canberra 1999.
19. Uwe E Reinhardt, 'Does the aging of the population really drive the demand for health care?' *Health Care,* vol. 22, no.6, pp. 27-39.
20. Pedro Pita Barros, 'The black box of health care expenditure growth determinants,' *Health Economics,* vol. 7, pp. 533-544, 1998.
21. C Van Weel, J Michels, 'Dying, not old age, to blame for costs of health care,' *Lancet*, vol. 350, pp. 1159-1160.

an increase in their supply: more doctors means more patients and if expensive new methods are made available, they will replace older, cheaper methods. The extent to which this contributes to overall better health is uncertain. In some cases, for instance in many new pharmaceuticals, it certainly does; other areas are far less rigorously tested. The tendency for demand to follow supply can be partly offset if there are reasonable policy controls over cost-effectiveness and price.

Developments in technology, a category which includes pharmaceuticals, are almost impossible to predict with any hope of precision but some probable trends are emerging. It may be that the seventy-year boom in pharmaceuticals, which began in the 1930s and 1940s with the first antibiotics and which put drugs, rather than surgery, at the very heart of medicine, may be slowing considerably. Since 2000 there have been almost none of the 'blockbuster' drugs which have such a powerful effect on national health budgets. Drug company development pipelines have become comparatively impoverished. New strategies of drug development, such as drug design, have not lived up to expectation: basic research continually turns up potential new biological targets for drug intervention, but developing the drugs to take advantage of these discoveries more often fails than succeeds.

Individually tailored therapies, many of them genetically based, are coming into wider use and may represent a continuing and growing trend. New technologies almost always start expensively and become cheaper; many techniques which are now highly labour-intensive are likely to become quicker, cheaper, more successful and more automated. And, unlike drugs, they tend to be one-off therapies: expensive at the time of delivery, but not in need of repetition.

It is worth remembering what we are buying with our health dollars. Better health produces a society which functions better, in economic as well as social terms. A recent policy paper from the Australian Treasury confirmed the economic benefits of an efficient and effective health care system which makes its own contribution to wealth.[22] More importantly, an effective health system has become one of the key elements which the people of most developed countries – including Australia – demand of their governments. Ever since the Bronze Age, leaders have based the legitimacy of their rule on their capacity to provide their people with personal and group security. Until the development of modern medicine, this was largely limited to civil law-and-order and protection from foreign invasion. But in the contemporary world, threat to personal security – at core, the protection of life – is at far greater threat from illness than from invaders, terrorists or criminals. Health is a national security issue. A system of government which fails to provide an effective, functional and accessible health system loses one of the most important foundations of its legitimacy.

22. Joann Wilkie, Adam Young, *Why health matters for economic performance,* Australian Treasury, Canberra 2009.

Older, poorer, sicker

Nowhere in Australia does the public have confidence in the capacity of the public health care system to deliver the services they believe are necessary and reasonable. A recent national survey, for example, revealed only 30% of respondents believed the overall public and private system of hospitals and primary care 'worked pretty well', 56% thought 'there were some good things about it' and 14% believed it needed to be 'completely rebuilt'. Public hospitals and aged care were the least well-regarded of all health services, with only 39% satisfied with public hospital services.[23] In another survey, 94% of respondents nominated hospitals and health care as the first priority for federal government spending.[24]

A recent analysis by the Australian Medical Association showed this lack of confidence was founded in the fact of poor hospital performance. Against all key indicators, the performance of the nation's public hospitals was found to be inadequate, often lethally so.[25] So when indicators of Tasmania's health system are found to be inadequate when measured against national averages, it should be remembered that those national averages represent standards which are themselves seriously deficient.

Almost all the indicators of health status and health system performance show Tasmania to have the least satisfactory system, even though the state's population is poorer, sicker and older and therefore most likely to need public health services. Rates of mortality, median age, average earnings, children in one-parent families, labour force participation and potentially avoidable deaths are all well above the national average, and in most cases are the worst in the nation.[26] The Bureau of Statistics' measure of avoidable deaths is particularly relevant in this context. It refers to the number of people who die from causes which effective public health, medical and surgical interventions could have prevented. It is thus a clear and stark indicator of the level of personal loss and human misery which has resulted from Tasmania's inadequate public health care system.

Table 10: Indicators of health status: Tasmania and Australia, 2010

Indicator	*Tasmania*	*Australia*
Death rate (per 1000)	6.7	5.7
Life expectancy at birth: males *(2008)*	77.7	79.2
Life expectancy at birth: females *(2008)*	82.3	83.7
Weekly ordinary time earnings ($)	1 150	1 300
Children in one-parent families	23.5	18.5
Labour force participation	60.50%	65.50%
Median age	39.9	36.9
Mean age	39.5	38.0
Avoidable deaths *(per 100 000)*	189.6	155.4

Source: ABS

23. Menzies Centre for Health Policy, *The Menzies-Nous Australian Health Survey 2010,* University of Sydney/Australian National University, November 2010.
24. Research Australia, *Health and Medical Research Public Opinion Poll 2010,* Research Australia, Canberra 2010.
25. Australian Medical Association, *Public Hospital Report Card 2010,* AMA, Canberra 2010.
26. Australian Bureau of Statistics, *State and territory statistical indicators 2011,* ABS, Canberra 2011.

The Bureau maintains a measure of socio-economic status across Australia, the Socio-Economic Indexes for Areas (SIEFA). The key indicator of relative disadvantage across states and territories is calculated by looking at the ten percent of census districts with the lowest level of economic well-being.[27]

Table 11: Socio-economic disadvantage by jurisdiction, 2001

State/ Territory	*% of census areas in lowest decile*
NSW	10.9
Vic	8.0
Qld	8.9
SA	12.0
WA	9.8
Tas	15.9
NT	28.3
ACT	1.6
Aust	10.0

Source: ABS

Tasmanians are also relatively sicker than people in most other jurisdictions. This is revealed by the ABS National Health Survey in statistics of risk factors (such as smoking, obesity and alcohol intake), current long-term conditions and self-assessed health status. In the self-assessment measure, those who rate themselves as in excellent or very good health is about the same as the national average but people who have some health problems seem to be sicker.[28]

Table 12: Self-assessed health status, Tasmania and Australia, 2007-8

Health status	*% of persons (Tas)*	*% of persons (Aust)*
Excellent/very good	50.0	55.8
Good	27.1	29.1
Fair/poor	18.0	15.1

Source: ABS

People with chronic health problems represent a major load on the health system. They also represent a most serious indicator of the human cost of poor health. Although Tasmanians do not suffer substantially more cancer or mental health problems than other Australians, they suffer from significantly more chronic problems.

Lifestyle risk factors – whether people lead generally healthy lifestyles or not – is a powerful indicator both of the health status of a society and of the likely future demand on health services. The seven top lifestyle causes of disease in Australia are, in order, tobacco, blood pressure, overweight and obesity, physical inactivity, blood cholesterol, alcohol and low intake of fruit and vegetables. These factors tend to occur more in people with lower incomes and educational status; therefore, it is to be expected that some of these will occur with a higher frequency in Tasmania than in the rest of Australia. In fact, the major differences occur in only two categories – smoking, where the Tasmanian average is higher than the nation's as a whole; and consumption of fruit and vegetables, in which (if the 11% figure below is not simply a statistical artefact) the Tasmanian lifestyle is substantially healthier. These two factors probably do not cancel each other out: smoking

27. Pramod Adhikari, *Socio-economic indexes for area: Introduction, use and future directions,* Australian Bureau of Statistics, Canberra 2006, p.13.
28. Australian Bureau of Statistics, *National health survey: Summary of results, 2007-2008 (Reissue),* ABS, Canberra 2010.

is extraordinarily dangerous, and Tasmania does have a somewhat disproportionate obesity problem. Nevertheless, the whole of the state's poor health outcomes may not be due to demographic and lifestyle factors.

Table 13: Lifestyle risk factors, Tasmania and Australia, 2007-8

Risk factor	*% of persons (Tas)*	*% of persons (Aust)*
Current daily smoker	23.3	18.9
Risky/high alcohol	13.6	13.4
Sedentary/low exercise	72.1	72.3
Inadequate fruit/vegetable	11.0	93.8
Overweight /obese (measured)	64.0	61.2

Source: ABS

More recent AIHW figures show a reduction in the numbers of Tasmanian smokers. In a 2010 survey, 15.9% of people in Tasmania over the age of 14 smoked daily, against a national average of 15.1%. In the 2007 survey the figures were 22.6% and 16.6% respectively.[29] But care must be taken in interpreting these results. They are from surveys, not censuses, and their samples necessarily change for every survey, so longitudinal comparisons may be misleading. It is sensible to be particularly suspicious of unexpected results or sudden changes – such as the new Tasmanian smoking figures and the Bureau of Statistics' fruit and vegetable figure.

If demography and behavioural risk are not the only cause of disproportionately poor health, we must also look at the health system itself. Because neglected health problems tend to get worse and to cause new, serious and expensive complications, lack of funding resulting in the failure of the system to deal with new presentations in a timely, accessible and efficient way, is likely to produce massive economic inefficiency, social inequity, premature deaths and avoidable illness.

29. Australian Institute of Health and Welfare, *2010 national drugs strategy household survey report,* AIHW, 2011.

A constant state of crisis

In the short term, underfunding of a health and hospital system saves money. In a particular year, failure to make adequate investment in health will improve a government's budgetary position, reduce the need for borrowing, enable politically popular tax cuts, and stimulate the non-health economy. But when the underfunding option is pursued every year for decades, the system becomes not only unable to cope adequately with sick and vulnerable people but its economic efficiency plunges. An inadequate system will focus on the most seriously ill people, including those who would face imminent death without immediate care. Earlier intervention, which is often the key to avoiding later, much more expensive treatment, becomes less and less possible. The levels of illness and avoidable death rise; productivity and quality of life decline. All of these represent an economic cost to the community.

It is not within the scope of this paper to provide a comprehensive assessment of every aspect of the state health system. Rather, we shall look at how Tasmania performs against its peers in two central areas: the flow of patients from ambulances, though emergency departments to medical and surgical wards; and waiting times for elective surgery.

Bed occupancy, emergency overcrowding and ambulance ramping

An example of the flow-on effects of the shortage of acute inpatient beds in Tasmania's major hospitals illustrates the point. Bed occupancy rates are not reported by the Tasmanian government, but evidence which has become publicly available indicates that the two major hospitals, the Royal Hobart and the Launceston General, have had extended periods of occupancy greater than 100%.[30] Doctors have regularly reported such levels to the state branch of the AMA.[31] In September 2009 the CEO of the Launceston General was quoted as saying the hospital had been running at over 100% occupancy for more than 12 months.[32] The Tasmanian Health Minister, Michelle O'Byrne, confirmed to a parliamentary estimates committee that the situation had not improved:[33]

Table 14: Average inpatient bed occupancy rates, major Tasmanian hospitals, 2010-11

RHH	*LGH*	*NWRH/MCH*
98%	97%	81.5%

Source: DHHS

These levels of average occupancy indicate that the state's two major hospitals are still experiencing extended periods at or above 100% occupancy and are probably operating well above a safe level all the time. There may be no ideal rate of bed occupancy[34] but there is strong evidence that a rate

30. Occupancy over 100% are possible when patients discharged in the morning are replace in the afternoon of the same day by new admissions.
31. Australian Medical Association, *Public Hospital Report Card 2010: An AMA analysis of Australia's public hospital system,* AMA, Canberra 2010.
32. Danielle McKay, 'State hospital stampede'*, Sunday Tasmanian*, Hobart 20 September 2009.
33. Michelle O'Byrne, 'Estimates Committee A – Part 1, *Hansard*, Hobart, 28 June 2011.
34. Christopher A Bain et al, 'Myths of ideal hospital occupancy', *Medical Journal of Australia*, vol 192 no 1, p 42, Sydney 4 January 2010.

which persistently climbs above about 85% is unsafe. There are several reasons for this. Staff may become too busy to deal with emergencies as quickly as they might otherwise. Mistakes can happen when staff are overworked or tired. Infection rates, including of methicillin-resistant *Staphylococcus aureus* (MRSA), have consistently found to be substantially worse in hospitals with higher levels of occupancy.[35, 36] An extra bed added to a three-bed room has been associated with a threefold increase in transmissions of one strain of this dangerous infection, MRSA4.[37] High occupancy rates have been associated with pneumonia treatment failure,[38] delays in treatment of people with broken legs,[39] increased rates of *Clostridium difficile* infection,[40] premature discharge from intensive care units and higher rates of readmission.[41]

A more frequently cited effect is known as access block (or bed block), when patients remain in emergency departments for longer than is clinically indicated because beds cannot be found for them on medical or surgical wards. There, they require vigilant care from often-overworked staff and contribute markedly to emergency department overcrowding. A review of some 200 studies from Australia and overseas found that people affected by access block, and who spend too long in emergency, are 20% to 30% more likely to die. The authors estimated, using 2003 levels of access block, that this amounted to around 1500 deaths in Australia in that year.[42] If that figure was extrapolated to Tasmania on a population basis, it would mean about 75 people died avoidably in Tasmanian hospitals in 2003 as a result of access block alone. This is likely to be a conservative figure: such evidence as exists indicates both that access block in Tasmania's two main hospitals is worse than the national average and that levels have increased significantly since 2003, so 75 should be taken as a minimum figure. A more realistic rate is likely to be in the 90-100 range. Tasmania's road toll in 2010 was 31 deaths.[43] The conclusion to be drawn from these figures is that access block alone is killing about three times as many Tasmanians as road accidents.

The failure to invest in enough inpatient beds and in enough practical alternatives to acute inpatient care contributes to economic inefficiency in another way. According to the Tasmanian government, keeping a patient in an emergency department costs twice as much as keeping them in a medical or surgical ward.[44]

Another problem for Tasmania is that a under-investment in public hospitals (including in alternatives to expensive acute inpatient accommodation) has been accompanied by an over-investment in private facilities: when private hospitals are included, Tasmania has a higher *per capita* number of beds than any other state or territory, 4.6 per 1000 according to both AIHW and

35. Andrew Keegan, 'Hospital bed occupancy: more than queueing for a bed', *Medical Journal of Australia,* vol. 193 no. 5, pp. 291-293.
36. Department of Health (UK), *Hospital organisation, speciality mix and MRSA,* Report no 9163, December 2007.
37. M A Borg, 'Bed occupancy and overcrowding as determinant factors in the incidence of MRSA infections within general ward settings', *Journal of Hospital Infections*, no.39, pp.316-318, 2003.
38. R Sikka at al, 'ED overcrowding is associated with an increased time to pneumonia treatment,' *American Journal of Emergency Medicine*, Vol. 28, no. 7, pp. 809-812, September 2010.
39. D Richardson, K L McMahon, 'Emergency department access block occupancy predicts delay to surgery in patients with fractured neck of femur,' *Emergency Medicine Australia,* Vol 21, no. 4, pp. 304-308, Melbourne 2009.
40. K Kaier et al, 'Correlations between bed occupancy rates and *Clostridium difficile* infections: a time-series analysis,' Epidemiology *of Infections,* vol. 139, no. 3, pp. 482-483, March 2011.
41. C A Chrush, *et al*, High occupancy increases the risk of early death or readmission after transfer from intensive care, *Critical Care Medicine,* vol. 37 no. 10, pp. 2753-8.
42. Roberto Forero, Ken Hillman, *Access block and overcrowding: a literature review,* Simpson Centre for Health Services Research, University of NSW, Sydney 2010.
43. Bureau of Infrastructure, Transport and Regional Economics, *Road deaths Australia: 2010 statistical summary,* BITRE, Canberra 2011, p.2.
44. Department of Health and Human Services, *National partnership agreement 2009: Taking pressure off public hospitals implementation plan, Tasmania 2009-2013,* DHHS, Hobart 2010, p.12.

DoHA figures, compared with 3.9% for the nation as a whole. But its ratio of private to public is by far the highest in the country: 42.3% of all Tasmanian hospital beds are in private hospitals. Only 43.5% of Tasmanians have any sort of private hospital insurance coverage, regardless of the level of cover and the out-of-pocket expenses they might incur.[45] As a result, private hospital occupancy rates are low – around 70% – and under present arrangements are effectively inaccessible to a large proportion of a relatively low-income state population. The state's largest private operator, Calvary Health Care, reports high occupancy for one facility, St John's in Hobart (which performs many day-care services) but low rates at its three larger hospitals, Calvary in Hobart, and St Vincent's and St Luke's in Launceston.

Table 15: Active beds and occupancy rates, Calvary Health Care, Tasmania, September 2011

	Calvary, Hobart	*St John's, Hobart*	*Launceston*
Active beds	178	78	140
Occupancy	78%	103%	55%

Source: Calvary Health Care

These figures do not take account of some hundreds of beds which have been taken out of active use because their levels of use did not justify their continued staffing and upkeep. If private facilities were more fully utilised, and made available to the whole population rather than only to those who can afford them, the shortage of overall beds and the consequent safety concerns would disappear. Both the state Liberal opposition and the federal Labor government proposed almost identical schemes for the large-scale purchase of services from the private sector but these foundered because they would have involved major extra costs to the state – which no Tasmanian government can afford. Only the Commonwealth has the resources to put into place a broad, cost-effective scheme which would give access for the whole population to these under-used hospitals.

Table 16: Total numbers of active public and private beds and proportions per 1000 population, 2009-10[46]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Public (no)	18 651	13 032	10 453	5 163	4 632	1 280	907	694	54 812
Public/1000	2.6	2.4	2.3	2.3	2.8	2.5	2.6	3.0	2.5
Private (no)	6 323	6 880	5 945	3 085	2 158	939	328	120	25 778
Private/1000	0.9	1.3	1.3	1.4	1.3	1.9	0.9	0.5	1.2
Total	24 934	19 912	16 398	8 248	6 790	2 219	1 235	814	80 590
% private	25.3	34.5	36.2	37.4	31.8	42.3	26.5	14.7	32.0

Source: AIHW

These figures include psychiatric hospitals but not private free-standing day hospital facilities (in Tasmania less than 0.1 per 1000).

Generally, Australia has fewer beds *per capita* (public and private) than most comparable nations, except for the troubled systems of Britain and the United States. Canada's low bed numbers reflect its capacity to develop viable alternatives to inpatient care with, therefore, a much lower admissions rate. The Australian national average, then, is perhaps not the best benchmark. While most countries have over several decades reduced bed ratios and achieved increased efficiency associated with shorter hospital stays, Australia as a whole compares unfavourably. There are many factors limiting people's access to health services but a shortage of hospital beds, wherever it occurs, is certainly one of them.[47]

45. Private Health Insurance Administration Council, *Quarterly statistics,* PHIAC, Canberra June 2011.
46. AIHW, *Australian Hospital Statistics, 2009-10.*
47. Organisation for Economic Development and Cooperation, *OECD health data 2011,* stats.oecd.org/ (accessed 13/09/2011).

Table 17: Total inpatient beds per 1,000 population, various OECD countries, 1998 and 2008

	1998	*2008*
Australia	**4.1**	**3.8**
Austria	8.2	7.7
Belgium	7.9	6.6
Canada	4.4	3.3
France	8.4	6.9
Germany	9.3	8.2
Ireland	6.4	4.9
Italy	5.6	3.8
Japan	15.0	13.8
United Kingdom	na	3.4
United States	3.7	3.1

Source: OECD

Overcrowding in Tasmania's emergency departments, with a substantial contribution from access-blocked patients, results in ambulances being unable to discharge their patients. In larger cities, hospitals may indicate that they are 'on bypass' – that any case except the most critical must be taken to another hospital. This is highly unsatisfactory but it provides, at least, another option.

In Tasmania, with only one major hospital in each region, there is usually no such option. The result, particularly at the Royal Hobart Hospital, is that ambulances are 'ramped' – kept waiting outside the emergency department and unable to discharge their patients until hospital staff are ready to attend to them. At busy times, several ambulances can be ramped at once in a process which, in some cases, can take several hours.

Table 18: Ambulance ramping, by total patients, hours and patients ramped for more than two hours, Royal Hobart Hospital, 2007-8

	Jul	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*
Pat.	429	408	315	353	317	309	369	324	342	229	377	330
Hours	291	236	176	254	160	150	190	210	218	109	258	333
>2hr	29	18	11	28	8	9	13	11	31	9	24	55

Source: DHHS

Recent figures, unpublished but given in answer to a parliamentary question, show that a patient at the Royal Hobart Hospital is not counted as being ramped unless the delay is over 15 minutes; and that the average ramping time for July 2011 was 41 minutes.[48] This does not, of course, reveal how many people had to wait for longer than one or two hours before being seen.

Plausibly, there is an increased mortality rate associated with ramping. Patients ill enough to require an emergency ambulance to take them to hospital usually need the attention of a doctor; ambulance officers do not have medical training and are not equipped to do more than stabilise such patients until they can receive specialist care. A case control study at a Queensland hospital in 2007 could not find an association between ramping and an increased death rate, but the study's sample had a median ramp time of only 11 minutes. Research into patients who wait longer may provide a different answer. This study did, however, find ambulance ramping was associated with longer

48. Michelle O'Byrne, *House of Assembly Hansard: question time,* Parliament of Tasmania, Hobart 22 September 2011.

waiting times, with 34% of ramped patients having to stay in emergency for longer than eight hours, compared with those who were not ramped.[49]

A more easily confirmed result of ramping is that ambulances waiting to discharge their patients outside hospitals are not available to attend to emergencies elsewhere. In busy times, this is likely to be a significant cause of blow-outs in response times, though definitive studies in the Tasmanian context do not appear to have been undertaken. It is also probable that ramping contributes to the need for extra investment in increased numbers of ambulance vehicles and paramedics, representing yet another aspect of economic inefficiency caused by long-term underinvestment. According to the DHHS, Up to 13 hours per day are lost to the ambulance service as a whole by crews being unable to respond to new calls because they are delayed by ramping.[50] Attempts have been made to improve this situation, largely by changes to patient flow, but the fundamental cause remains: a ward which is full cannot take any more patients. Until the very large backlog in investment has been comprehensively addressed, no major or long-term improvement in these indicators can be expected.

Another key indicator of emergency department overcrowding is how long it takes to deal with patients. Emergency presentations are assigned to one of five triage categories, depending on seriousness and urgency. The Australasian College of Emergency Medicine has set the national guidelines for the maximum time people in the various categories should have to wait, ranging from immediate resuscitation to two hours for non-urgent cases. In all but the two most critical categories, Tasmania's performance is well below the rest of the nation.[51]

Table 19: Emergency department performance by triage category
12 months to 30 June 2011

	Resuscitate	*Emergency*	*Urgent*	*Semi-urgent*	*Non-urgent*
Benchmark	*Immediate*	*10 min*	*30 min*	*1 hr*	*2 hr*
% on time, RHH	99.8	76.9	31.6	35.8	74.1
% on time, LGH	100.0	53.2	52.7	59.5	88.9
% on time, NWRH	100.0	88.2	90.0	88.3	96.3
% on time, MCH	100.0	83.4	74.3	76.4	93.9

Source: DHHS

The superior performance in North-West Tasmania may be explained by four factors: lower demand from a smaller population; two emergency departments close to one another; lower bed occupancy rates in general wards; and greatly increased funding for the area with the Commonwealth's ownership of the Mersey Community Hospital at Latrobe.

It is often claimed that patients presenting at emergency departments for services which could be undertaken by general practitioners also represent a major and avoidable load on emergency departments and that overcrowding[52] can be successfully addressed by providing alternative and cheaper options, such as GP-style clinics attached to hospitals. Such a measure might be within the financial capacity of Tasmanian governments. This has appeal for policy-makers and, at first glance, might look like an effective response.

49. Maree Hitchcock et al, 'The effects of ambulance ramping on emergency department length of stay and in-patient mortality', *Australasian Emergency Nursing Journal*, vol 13, no 1, May 2010, pp.17-24.
50. DHHS, *National partnership agreement,* p. 9.
51. DHHS, *Progress chart,* Hobart September 2011.
52. ED overcrowding is defined as the situation where ED function is impeded by excessive patient load with a likely decline in quality as well as timeliness of care. Australasian College of Emergency Medicine, 'Policy document – standard terminology', *Emergency Medicine,* Fremantle 2002, vol. 14, pp. 337-340.

GP-style presentations are defined by the Australian Institute of Health and Welfare as those in which the patient:

- was in triage category 4 or 5 (semi-urgent or non-urgent);
- did not arrive by ambulance, police or correctional vehicle;
- was not admitted to the hospital, not referred to another hospital and did not die.[53]

In Tasmania in 2009-10, there were 47,182 GP-style presentations to hospital emergency departments, representing 43% of all ED presentations in that year.[54] But researchers at the Australian National University developed a mathematical model for estimating general practice workload in EDs. After taking into account more factors than the AIHW – including the actual complaint and whether the patient was self-referred or referred by a GP, they found in the hospital being studied that GP-type cases represented an ED workload of 10% to 14%.[55] A 2003 study found that taking away the least complex 20% of cases would reduce the complexity load on the department by only 3.5%.[56] Richardson and Mountain have estimated workload this nationally at around three per cent:

> Discretionary presentations by patients with low-complexity conditions, who might reasonably be managed elsewhere, constitute an insignificant workload in most EDs … They rarely require admission or even use of trolleys, they use minimal ED resources (less than three per cent in most EDs), are easy to deal with and do not impose on the key functions of the ED (assessment of sick patients, complex treatments and resuscitation).[57]

Increasing the availability GP-type services at no cost to the patient has often been popular and useful, but has not had a significant effect on ED presentations. A large-scale trial in the Hunter region of NSW involved multiple clinics, free transport and a patient helpline. These clinics were well attended but analysis showed that at the region's largest and busiest ED, at the John Hunter Hospital, there was an average reduction in attendances of only one patient every two hours attributable to the clinics.[58]

On the other hand, a 2008 survey of all Australian hospital emergency departments found that looking after patients for whom inpatient beds could not be found amounted to around 40% of the staff workload in large hospitals (a category which includes the Royal Hobart and Launceston General) and more than 30% overall. The survey revealed that the capacity to deal with a surge in patient numbers, such as a major disaster or terrorism incident, varied from inadequate to non-existent.[59]

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53. AIHW, *Australian hospital statistics 2009-10: Emergency department care and elective surgery waiting times*, AIHW, Canberra 2010, p.13.
54. *Ibid.*, p.14.
55. Australasian College of Emergency Medicine, *Access block and overcrowding in emergency departments,* ACEM, Melbourne 2004.
56. P. Sprivulis, 'Estimation of the general practice workload of a metropolitan teaching hospital emergency department', *Emergency Medicine Australasia,* Melbourne 2004, vol. 16 pp. 59-64.
57. Drew B Richardson and David Mountain, 'Myth versus fact in emergency department overcrowding and access block, *Medical Journal of Australia,* vol. 190 no.7, Sydney 6 April 2009.
58. ACEM, *ibid*, p.14.
59. Drew Richardson, *2008-2 Access block point prevalence survey,* Road Trauma and Emergency Medicine Unit, Australian National University, Canberra 2008.

There is room for the major Tasmanian hospitals to become more operationally efficient in their use of beds, though achieving national efficiency benchmarks would not return them to safe levels of occupancy. The amalgamated data for public hospitals show that in 2009-10 it cost 11.1% more on average to treat a patient for a given condition than the national average.[60]

Table 20: Cost per casemix-adjusted separation, public hospitals, 2009-10

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
All	4 718	4 682	5 159	5 017	4 716	**5 455**	4 989	5 517	**4 853**
Major	4 526	4 589	5 060	4 514	4 398	**5 148**	n.p.	5 458	**4 681**

Source: AIHW

Excludes depreciation, includes psychiatric hospitals

On a per-service basis, the Tasmanian hospitals pay more for nursing, administration, superannuation, medical supplies, drugs, food and salaried doctors. But a closer look at the figures reveals that much of this apparent inefficiency is related to one factor: medical patients spend much longer in hospital than similar patients with similar conditions elsewhere, or than surgical patients in the same hospitals.

Table 21: Relative stay index, directly standardised, public hospitals, 2009-10

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Medical	1.03	0.90	0.91	0.97	0.99	**1.08**	0.98	1.11	**0.96**
Surgical	1.10	0.99	1.05	1.08	1.08	**1.04**	0.96	1.49	**1.05**
Other	1.16	0.99	1.05	1.01	1.08	**1.03**	1.00	1.42	**1.06**
Total	*1.06*	*0.94*	*0.97*	*1.01*	*1.03*	***1.06***	*0.97*	*1.25*	***1.00***

Source: AIHW

An index figure of less than 1 indicates a patient's average stay is shorter than would be expected according to Casemix-adjusted data; greater than 1 indicates stays are longer.

Other data show Tasmania's hospital salaries are not higher than elsewhere, and most of the categories showing increased costs are heavily affected by the length of time a patient occupies a bed.[61] This relatively inefficient performance is likely to be related to discharge procedures in need of updating, and to cultural issues among public hospital medical staff in Tasmania. These may be forced to change with the introduction of activity-based (Casemix) efficient-price funding, if hospitals are to avoid being penalised. Reforms of hospital processes to reduce length of stay are associated with increased, not decreased, patient satisfaction. Shorter-stay patients also have lower wound infection rates and lower use of pathology services.[62]

The evidence supports the conclusion that the only way of decisively addressing avoidable morbidity and mortality associated with ED overcrowding and access block is to establish and adequately staff substantial numbers of new inpatient beds, and to develop and resource alternatives to acute inpatient care. As demand on hospital services continues to rise, and the available financial resources of Tasmanian governments continue to decline, it has become clear that the solution to this problem – and the key to saving a large number of lives – relies on the Commonwealth.

60. AIHW, *Australian hospital statistics 2009-10.*
61. *Ibid.*
62. Neville Board, Gideon Caplan, 'Implications of decreasing surgical lengths of stay,' *Australian Health Review,* vol. 23, no. 2, Canberra 2000.

Elective surgery

For decades, the resourcing of public hospitals has increasing failed to keep up with demand. They have had to concentrate on the most urgent cases, continuing to treat emergencies while neglecting cases that, for the moment, are less urgent. Saving lives is more important than, for instance, relieving discomfort or restoring mobility, even though neglect of some initially less-urgent cases can lead to serious and expensive complications later on. Data on elective surgery, usually defined as a procedure which can be delayed for at least 24 hours, are important indicators of the extent of this trend and the impact on patients' lives and health. Tasmanians have less access to elective surgery than almost anywhere else in the nation and, when their procedures are finally undertaken, have to wait for much longer.[63]

Table 22: Elective surgery waiting times, public hospitals, 2008-09

	Admissions	*Median wait (days)*	*Seen on time (%)*	*Waiting >1 year (%)*
NSW	199 384	39	91.0	2.5
Vic	147 690	31	85.4	2.9
Qld	109 940	27	84.7	1.8
WA	60 398	31	85.6	2.0
SA	44 152	36	86.8	2.7
Tas	**16 931**	**44**	**65.4**	**13.1**
ACT	10 104	75	65.5	10.6
NT	6410	40	70.3	5.6
Aust	**595 009**	**34**	**86.2**	**2.9**

Source: DoHA

For many years, elective surgery waiting lists have been the focus of public attention and government anxiety. But the waiting lists figures, disappointing as they are, are often flawed measures which give an unduly optimistic view of the state of the system. They can be manipulated, for instance by governments ordering more cheap procedures (such as cataract removal) and fewer expensive ones (such as knee and hip replacements). And there is much they do not capture. Patients' names do not go on the waiting lists until they are put there by a surgeon – but first they must get to see the surgeon and be assessed as being suitable for an operation. People are removed from waiting lists when they have been admitted to the hospital for their operation. But people who have been out of contact for too long are also removed from the list, as are those who lose contact for too long, go private, give up or die.

Tasmania's poor performance is again evident when looking in detail at the reasons people are removed from the lists. Of those who were not contactable or died, 36.2% had waited more than a year – twice the national average of 18.6%. Of those who had gone elsewhere, probably to a private hospital, 25.1% had waited more than a year, against a national average of 10.7%. Of those in the 'surgery not required or declined' category, which includes those who had simply given up, 34.8% had waited more than a year, compared with a national average of 12%.[64]

The temptation of governments to undertake cheap procedures rather than expensive ones is difficult to document but is evident in the results of the evaluation of the Commonwealth's Elective Surgery Reduction Plan. Nationally, this made $300 million available on a population-share basis to improve waiting lists. Of this money, $252 million was reward money if certain targets were

63. DoHA, *The state of our public hospitals,* Canberra June 2010, p. 77.
64. AIHW, *Australian Hospital Statistics2009-10: Emergency and elective,* p.41.

reached. Potentially, Tasmania's share would be $15 million, a relatively insignificant amount when compared with the task to be tackled.

Tasmania, together with all states and territories, reached its target in raw volume terms: it was given a target of 21,668 elective surgery admissions and achieved 24,616. But it failed the cost-weighted test, which evaluated whether there had been too many cheap procedures to boost the raw volume total. The state was therefore given $3.7 million, 80% of its reward money.[65,66]

Nationally, cataract extraction is the most common of all elective procedures. But the rate in Tasmania responded dramatically to the waiting list scheme's incentive to boost raw volumes. These figures indicate how easily waiting lists can be manipulated, and how Commonwealth specific-purpose payments, aimed as they are at single elements of a complex and interrelated system, can distort both the provision of services and patient outcomes.

Table 23: Separations per 1,000 population for three procedures, 2007-10 before and during elective surgery waiting list program[67]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Cataract extraction (07-08)	8.3	7.9	9.6	8.9	7.3	**7.6**	5.7	6.5	**8.4**
Cataract extraction (08-09)	8.5	8.1	9.8	9.8	7.8	**8.1**	6.8	9.1	**8.7**
Cataract extraction (09-10)	8.9	8.3	9.4	9.8	7.7	**9.6**	6.9	8.1	**8.8**
Hip replacement (07-08)	1.2	1.2	1.3	1.2	1.5	**1.4**	1.2	0.6	**1.3**
Hip replacement (08-09)	1.3	1.4	1.2	1.5	1.5	**1.5**	2.4	0.8	**1.4**
Hip replacement (09-10)	1.3	1.5	1.2	1.6	1.5	**1.8**	2.3	0.5	**1.4**
Knee replacement (07-08)	1.7	1.3	1.6	1.7	1.7	**1.5**	1.8	0.7	**1.6**
Knee replacement (08-09)	1.7	1.4	1.7	1.7	1.8	**1.2**	2.6	0.9	**1.6**
Knee replacement (09-10)	1.7	1.5	1.8	1.8	1.9	**1.5**	2.5	0.5	**1.7**

Source: AIHW

Favouring cheap procedures has nothing to do with how long people have been on the waiting list. People receiving cataract operations have usually not been waiting long. Those eventually receiving hip or knee replacements have another story to tell.

Table 24: Waiting times for three procedures, Tasmania and Australia, 2009-10[68]

	Cataract		Hip replacement		Knee replacement	
	Tas	Aust	Tas	Aust	Tas	Aust
Days waited at 50th percentile	100	86	291	116	431	180
Days waited at 90th percentile	297	336	740	373	896	414
% waited more than 365 days	1.6	4.3	40.2	11.1	50.0	18.1

Source: AIHW

Getting to see a public hospital specialist in the first place – the initial prerequisite for your name to be put on a waiting list – can be equally difficult. Patients can spend as long waiting to see a surgeon or physician as they can on the official waiting list. This information is not usually published but one of the divisions of general practice, General Practice South, maintains records of

65. COAG Reform Council, *National partnership agreement on the elective surgery waiting list reduction plan: Period 3 assessment report,* COAG, Canberra 2011.
66. Department of the Treasury, *Budget paper no.2, 2011-12,* Hobart 2011.
67. AIHW, *Australian hospital statistics 2007-2008, 2008-2009 and 2009-10*.
68. *Ibid.*

the clinic waiting times at the Royal Hobart Hospital and lets its members know.[69] These figures are for surgical clinics; medical clinics have equally long waits.

Table 25: Waiting times for first appointments at surgical clinics (weeks)
Royal Hobart Hospital, October 2011

	Neurosurgery			*Ophthalmology*			*Orthopaedics*			*Paed. Surgery*			*Surgical A*			*Surgical B*			*Surgical C*		
Urgency	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**
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.

Using the private sector

Some mainland hospitals have found that the most effective way of improving their performances in elective surgery is to establish stand-alone facilities with their own staff and budgets. In Tasmania, this will not be possible without a major injection of new money; and, with so many empty beds in private hospitals, would be a questionable strategy in any case. The state already provides private hospitals with about seven per cent of their revenue through the purchase of services and cannot be expected to do much more.[70] An exhaustive and high-quality report by the Productivity Commission has shown that private hospitals are as safe as public and, in the elements over which they have control, as economically efficient.[71] They do not, however, employ most of the doctors, who bill patients directly and have almost total pricing power. Any substantial increase in demand could be expected to result in surgeons and anaesthetists putting up their fees, in response to the laws of the market. This would have a number of effects, all of them bad from the health policy point of view.

- Even if the government paid surgeons for the services it bought, higher fees in a generally more expensive market would hurt those patients still paying for services. These people would increasingly be excluded from surgery. Either health insurance premiums would rise and so too would the Commonwealth's 30% - 40% private insurance rebate, or out-of-pocket expenses would rise, or both.

- Increased demand and higher fees would force up the amount charged by surgeons if they billed the government.

- Public hospital surgeons who saw colleagues in the private sector earning much higher incomes would tend to leave the public system. The government would either have to pay them more to retain them or see them leave, with an obvious effect on the performance of public hospitals.

Under the proposed new system, a more comprehensive and cost-effective process would be possible. The upward pressure on doctors' fees could be controlled if all or most of the required surgeons and anaesthetists were employed, either by the private hospital operators or by a special unit within the public sector. The price to be paid for services could be guided by the public hospital efficient-price formula (Casemix) but, as this does not include some inputs such as capital depreciation or financial return on capital employed, would have to be augmented by an agreed

69. General Practice South, *Newsletter of General Practice South*, Hobart, October 2011, p. 12.
70. AIHW, *Health expenditure Australia 2008-09.*
71. Productivity Commission, *Public and private hospitals,* Research report, Canberra 2009.

amount. In the longer term, it would be possible to adapt the Casemix system to include these elements. A service agreement would be signed between the Purchasing Authority and each private operator for the provision of a defined number, type and quality of services, for a defined period of, say, three years. The inclusion of an element for capital depreciation would allow private hospitals to invest in capital – buildings and equipment – that is not possible now. Private hospitals have become run-down too: if they are to remain viable, they need some means of updating their facilities. Without a reasonable certainty of money-flow, a great deal of needed investment will remain impossible.

31 October 2011