Submission to the

Select Committee on Transfer of Care Delays (Ambulance Ramping)

Martyn Goddard
Policy analyst
[redacted]

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Introduction

This submission comprises two closely related reports on the effects on costs and services of long-term under-investment in Tasmanian public hospital infrastructure.

The core problem in our hospitals is not ambulance ramping or emergency department overcrowding. Those are symptoms, not the cause. Ramping will not be successfully addressed by buying lots of new ambulances or by increasing the size of the emergency departments. It will only be fixed when there are enough facilities to accommodate the large and growing number of patients needing admission.

The logjam in the medical and surgical wards means seriously ill patients in emergency departments cannot be transferred to specialist wards so they can get the care they need. Instead, those patients remain in the EDs, not only taking up space but, more importantly, requiring quite high-level care from staff who cannot then attend to people in the waiting area or in ambulances outside.

The solution is not only to provide more beds but, crucially, the right sort of beds.

There are no figures on how many patients in acute wards are there because there's nowhere else for them to go, but anecdotal reports from staff say it is considerable. A very senior staff physician estimated recently that about a quarter of patients in the General Medicine wards would be better care for somewhere else (and, inevitably, somewhere cheaper) but there is nowhere else. The same picture is likely on the surgical wards.

There is insufficient provision of aged care, convalescence, rehabilitation, and step-down sub-acute and non-acute facilities. But even in normal times, it costs around $2000 a day to keep someone in an acute bed who does not need that level of care.

The failure to invest has caused the current, escalating chaos in almost every part of our public hospital system. That, in turn, means staff can no longer work with anything like their normal level of efficiency. Even as the ability to meet demand falls away, per-patient costs are soaring. This, in turn, has serious implications for the state budget.

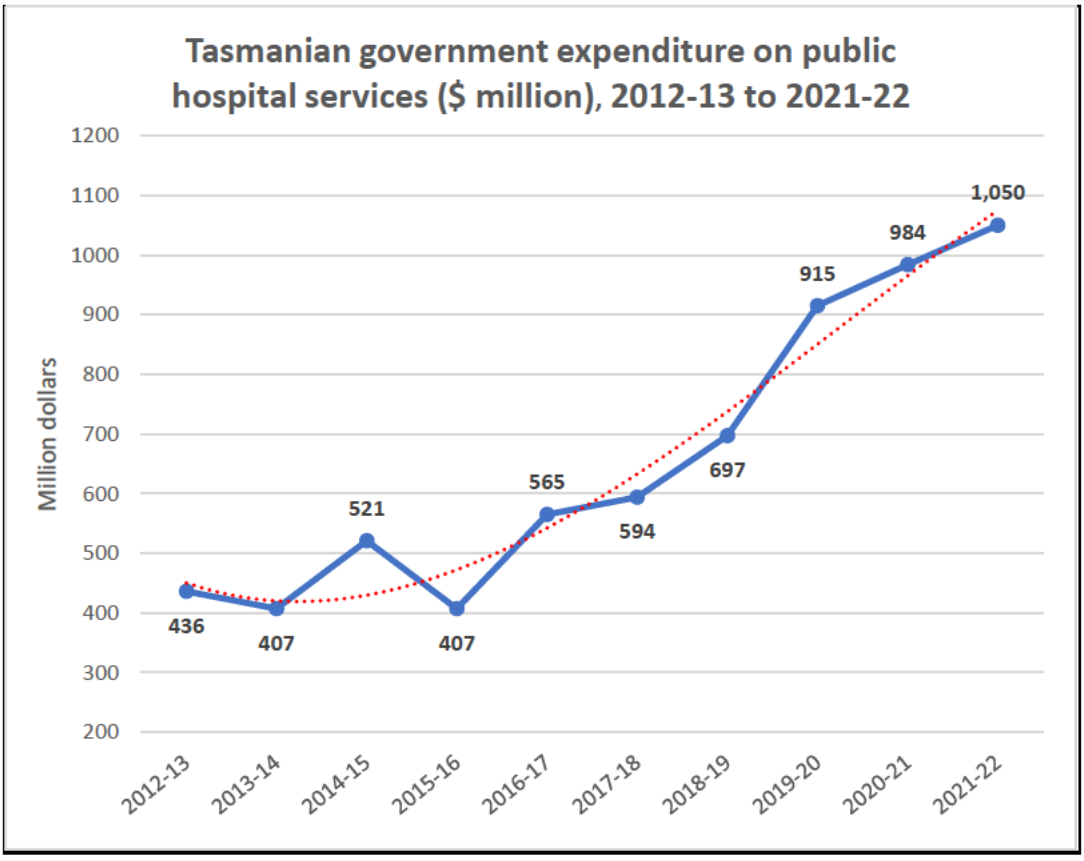
Until 2015-16, per-patient costs were in slow decline as the hospitals were able to become more efficient, with the number of patients being treated rising faster than the amount of money in the hospital budget. But 2015-16 was the tipping-point: the process went into reverse. As the dysfunction of overcrowding increased, the ability of staff to do their jobs decreased.

All states are experiencing similar problems, but nowhere to the extent now entrenched in Tasmania. This table shows what happened to the treatment costs of the average inpatient between the year of greatest efficiency and 2020-21. Tasmania's increases – 32.6% – is double that of Victoria, its nearest rival, and three times the national average.

Cost per weighted separation (acute admitted) by state				
	Lowest year	Lowest value	2020-21	% increase
NSW	2016-17	4,486	4,934	10.0%
VIC	2016-17	4,518	5,322	17.8%
QLD	2017-18	4,574	4,754	3.9%
WA	2017-18	5,504	5,699	3.5%
SA	2016-17	5,027	5,294	5.3%
TAS	2015-16	4,599	6,097	32.6%
ACT	2017-18	5,056	5,702	12.8%
NT	2016-17	5,883	6,716	14.2%
AUST	2016-17	4,641	5,153	11.0%
Source: Independent Health & Aged Care Pricing Authority				

Because Commonwealth funding is based on national averages, most of the costs of decreased efficiency accrue to the state. If Tasmanian hospitals were able to operate at the national average of efficiency, the state budget would be around $250 million a year better off.

This chart shows the trend in state government hospital expenditures over the most recent decade.[1] As you can see, the trend upwards has accelerated sharply.



1. Australian Institute of Health and Welfare, *Health Expenditure Australia.*

A model of poor public policy

How scrimping on hospital funding is backfiring on Tasmanian government finances

August 2023

Martyn Goddard
Policy analyst
[redacted]

A model of poor public policy

MAIN POINTS

- Over a decade, the number of patients admitted to acute hospital wards in Tasmania has increased by an average of 5% a year.

- But the number of acute beds has increased by only 3.3% a year.

- As pressure on staff grew, they became less able to work normally or efficiently.

- That has resulted in massive blowouts in per-patient costs. In 2020-21, each acute patient in Tasmanian public hospitals cost $944 more than the national average to treat.

- A similar situation exists in emergency departments. Each ED presentation now costs between 45% and 66% above the national average.

- Initially, the failure to build adequate hospital infrastructure saved the state government money. That changed from 2017-18, when costs escalated sharply in line with the increasingly frequent crisis situations in most hospital departments throughout the state.

- Federal government funding does not cover cost increases that are caused by state inefficiency. Until 2017-18, the Commonwealth's share of hospital funding was greater than the state's share. Since then, the Commonwealth's share has fallen to 40% and the state government's has risen to 55%. (The rest is paid by various patient insurances).

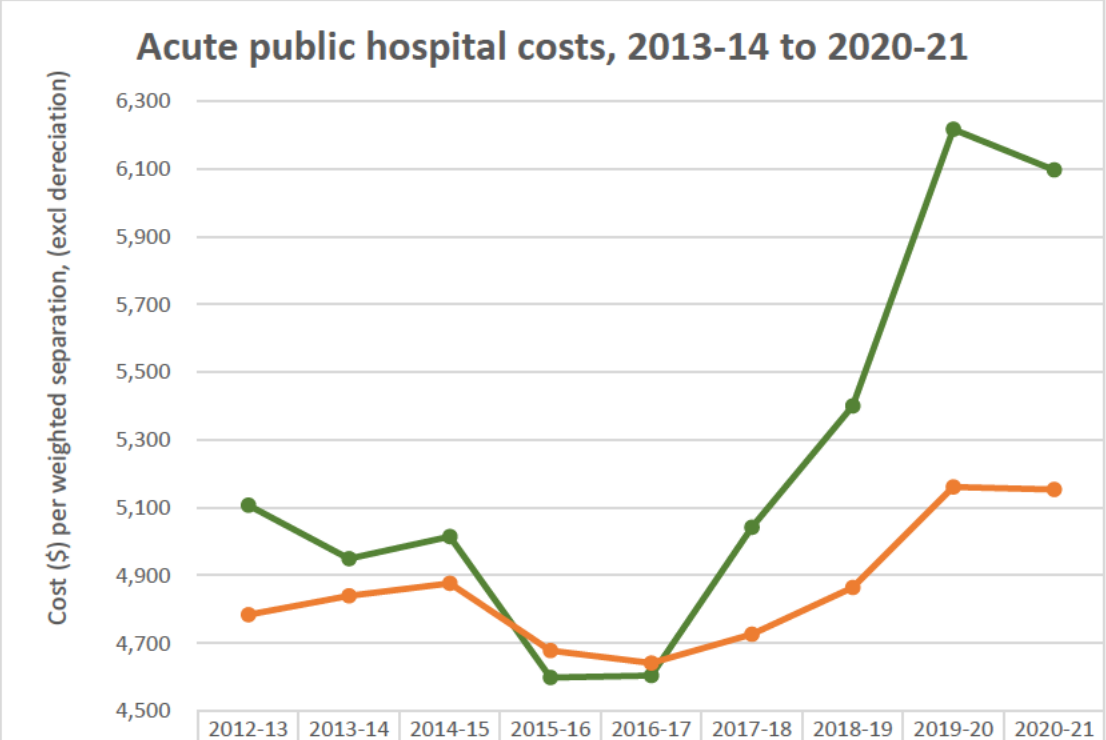
- **The increased cost now accruing to the Tasmanian budget was $287 million in 2018-19, $256 million in 2019-20 and $286 million in 2020-21.**

- **Over a normal four-year budget period that cost, almost entirely a result of the failure to provide adequate hospital infrastructure, is likely to amount to around $1.1 billion.**

A model of poor public policy

For many years, demand for public hospital services in Tasmania has outstripped their supply. The results of that continued shortage have been well documented and widely discussed. But until fairly recently, per-patient costs were kept low. There were more and more patients per staff member, so productivity increased and – despite the impact on people being denied care, and on the stress levels of staff, there were savings for the state budget.

After 2016-17, all that changed. The growing pressure and constant crises had got to the point at which staff could no longer work at normal levels of efficiency. Costs, which had been lower than the national average, soared. The weighted cost of each separation[2] rose from 1.7% below the national average in 2015-16 to 8.3% *above* by 2020-21.



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Tasmania	5,107	4,950	5,015	4,599	4,604	5,042	5,400	6,217	6,097
Australia	4,784	4,840	4,877	4,678	4,641	4,726	4,864	5,161	5,153

This trend predates the pandemic. In fact, costs fell slightly at that time (and stabilised in the rest of Australia) as fewer people sought care during the lockdowns.

2. A separation is a completed episode of admitted patient care. Costs per weighted separation are adjusted for cost and complexity, allowing valid comparisons to be made.

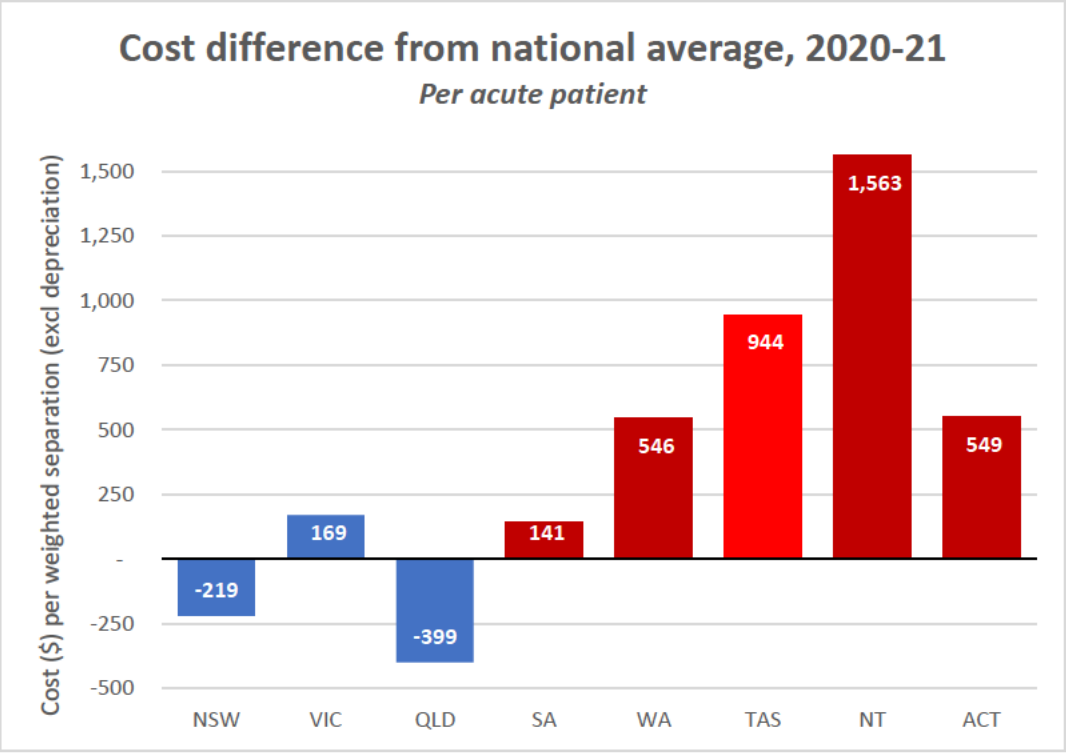
From the time the current national funding model was introduced in 2011, admissions to Tasmania's acute public hospital wards increased, on average, by 5,818 or 5% a year.

Rising hospital demand, 2012-13 to 2021-22 *Average annual increase in admissions*					
	RHH	LGH	NWRH	MCH	TOTAL
Average number change	2,603	2,155	829	232	**5,818**
Average percent change	4.8%	5.1%	8.00%	3.6%	**5.0%**
Source: AIHW, Hospital admissions data					

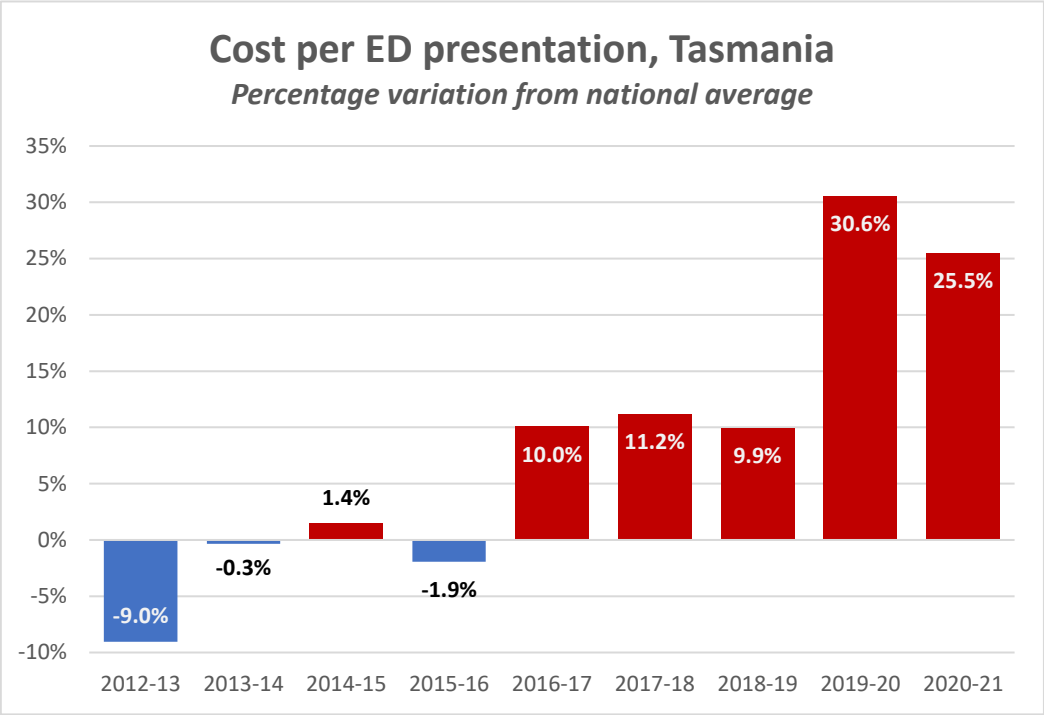
But bed numbers increased by an average of only 3.3%, or 44 beds, a year.

Public hospital beds in Tasmania: average annual changes										
	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	2019-20	2020-21	TOTAL
Number	0	-1	112	15	-10	36	76	56	111	**44**
Percent	0.0%	-0.1%	9.4%	1.2%	-0.8%	2.8%	5.7%	4.0%	7.5%	**3.3%**
Source: AIHW, Hospital resources										

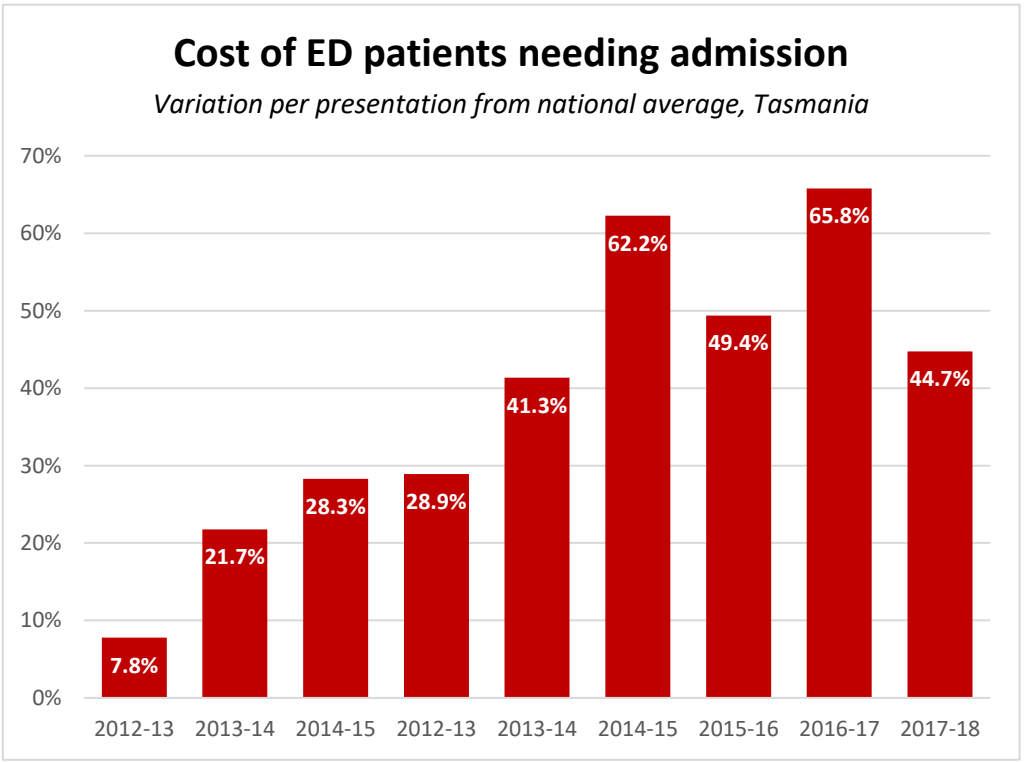
That situation was unsustainable in the long term. Ever since 2016-17, the previous budgetary savings have turned into a serious deficit. Apart from the Northern Territory – Australia's perpetual basket-case – Tasmania's costs of inpatient care are higher than in any other jurisdiction.



A similar pattern is found in emergency department care. After 2015-16, the cost of an ED presentation went from below the national average to around 25% - 30% above.



Increasing rates of bed-block – in which patients needing admission to a specialist ward have to be kept in the ED because there are no available beds – is responsible for a substantial share of the cost blowouts. As direct consequence of the failure to provide beds, the cost of treating each of these patients has doubled.

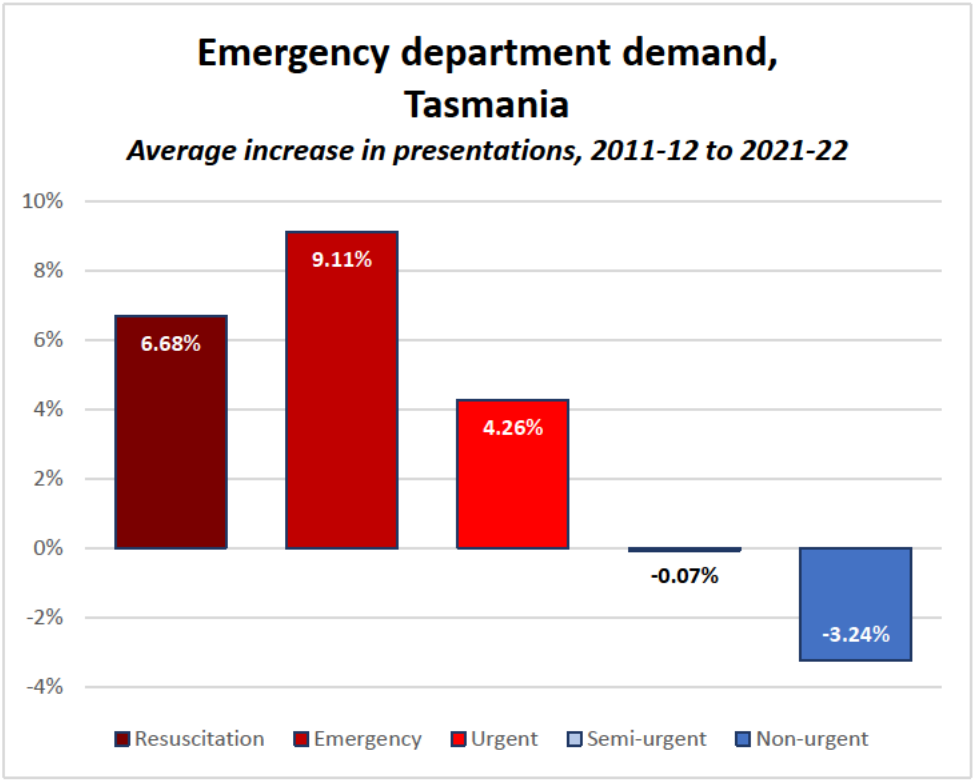


The main measure of bed block is the time waited in the ED at the 90th percentile by patients needing admission. That's the time in which 90% of these patients have left the ED and 10% are still waiting. This table shows how Tasmania's four main hospitals rank against the nation's 293 public hospitals with emergency departments.

Emergency Department bed block, Tasmania		
Hospital	10% still waiting at:	National ranking (out of 293)
Launceston General	30hr 26m	293
Mersey Community	26hr 20m	290
North-West Regional	20hr 38m	269
Royal Hobart	19hr 45m	262

When emergency departments cannot deal adequately with everyone, they must – like all other areas of a hospital – concentrate on the most serious cases. In Tasmania, the increase in presentations has been in the most complex and expensive triage categories: resuscitation, emergency and urgent.

Semi-urgent and non-urgent cases are increasingly staying away. According to staff, there are two reasons for this: people know they may have to wait for many hours, and they do not want to add to workload. This disproves the common assumption that people who could otherwise be cared for within general practice are instead crowding emergency departments. They are not. Instead people not able to see a GP are tending not to be treated at all.

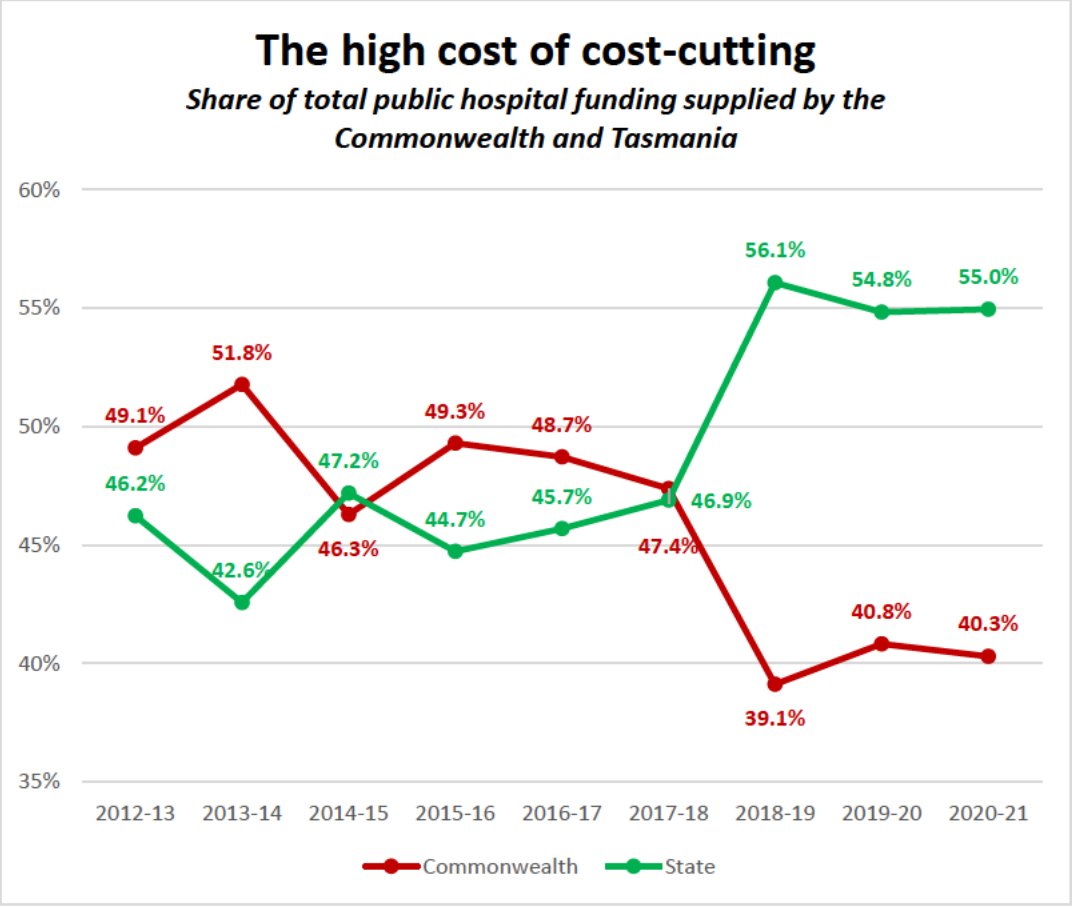


The impact on the state budget

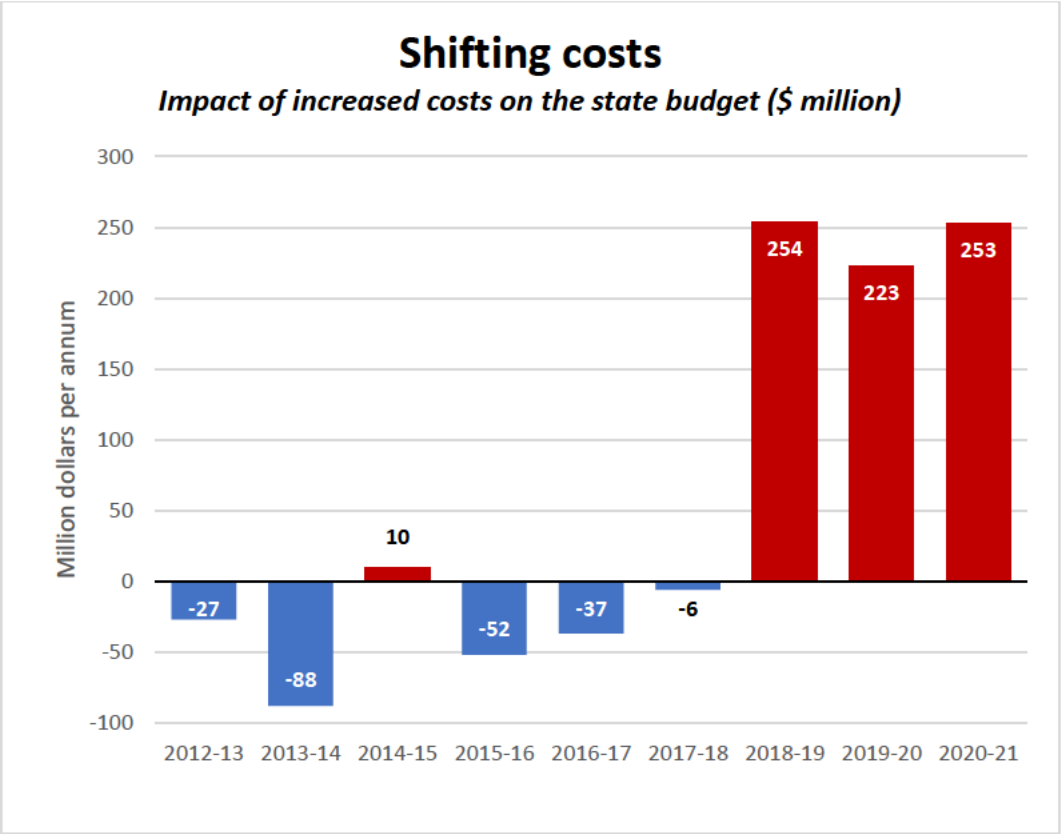
A policy aimed at saving money by scrimping on capital investment has, in the end, produced the opposite effect. That policy now costs the state budget more than a quarter of a billion dollars a year.

Commonwealth funding for state public hospitals is mostly based on a National Efficient Price, which the Independent Hospital and Aged Care Authority calculates to be the amount any reasonably efficient hospital needs. In other words, the federal government refuses to fund inefficiency. Any extra cost, above the efficient price, must be borne by the state.

This chart shows the effect on the state budget. Until 2017-18, the state and federal governments put about equal amounts into recurrent funding of Tasmanian public hospitals. Now, that has shifted to a 40% share for the Commonwealth and a 55% share for the Tasmanian government. (The rest comes from other sources, mostly various insurances carried by patients).



When expressed in dollar terms, the impact is dramatic.



The failure to provide enough resources – mainly hospital beds – no longer saves money. But even the chart above under-estimates the real impact.

Until 2017-18, the Commonwealth's share of funding was, on average, $33 million dollars *more* than the amount the state put in. So, with that figure as a baseline, we can see that the cost-cutting policies now add around $280 million a year to the Tasmanian government's share of recurrent hospital funding.

Increased costs to Tasmania	
2018-19	$287 million
2019-20	$256 million
2020-21	$286 million
Over three years	**$829 million**

The situation has been made worse by another cost-cutting policy originating, this time, in Canberra. The previous federal government put a cap of 6.5% on the annual increase in the cost of its main hospital funding program, no matter what happened to real increase in patient numbers, wages and other costs. The former government also abandoned incentive funding for improved elective surgery and emergency services.

These federal measures have affected all jurisdictions fairly equally by shifting costs onto the states and territories. While present also in Tasmania's case, they are a relatively minor element in the overall funding picture; but they again illustrate the futility of crude cost-cutting programs which, almost always, end up reducing efficiency, increasing real costs, and crippling services.

There is no reason to believe that the situation has changed since 2020-21 and many reasons to believe it may have become worse. In that case, the added cost to the state budget will amount to around $1.1 billion over a four-year budget period.

That money, if it had been used for capital investment, would not only have saved many millions of dollars in the long term but would have provided the Tasmanian people with a public hospital system that is fit for purpose. Instead, the state is paying heavily for a system that is failing on almost every parameter, including budgetary responsibility.

Data sources

Independent Hospital and Aged Care Pricing Authority:

National Hospital Cost Data Collection, (Rounds 17 to 25)

Australian Institute of Health and Welfare:

Admitted Patient Care, 2012-13 to 2020-21

Time Spent in Emergency Departments, 2011-12 to 2019-20

Hospital Resources, 2010-11 to 2020-21

Health Expenditure, Australia, 2011-12 to 2020-21

Last chance for change

A briefing paper on the new National Healthcare Agreement

At its meeting in November, the National Cabinet will have the first of many discussions on a new National Healthcare Agreement, which will redefine federal-state funding of public hospitals. The agreement will take effect in 2025 and will last for five years.

Under the current agreement:

- Under Activity-Based Funding. the Commonwealth funds 45% of the National Efficient Price of patient care. The efficient price is based on national averages.
- The annual increase in the Commonwealth funding is limited to 6.5%. The states are responsible for any increase in demand and cost inflation above 6.5%.[3]

As well, the Commonwealth pays for part of the private health insurance premiums of private patients treated in public hospitals; veterans; some pharmaceuticals; and other programs. Hospitals also raise money from patients, mostly though various insurances. In reality, as the independent data reveal, the Commonwealth's share of recurrent costs amounts to substantially less than 45%.

Public hospital recurrent funding, 2020-21

	Commonwealth	State	Other	Total
$ million	28,052	37,295	5,179	70,526
Share	39.78%	52.88%	7.34%	100%

Source: AIHW, Health Expenditure Australia

Everywhere, patient demand outstrips bed availability

Average annual change in bed numbers and in patient numbers, 2010-11 to 2019-20

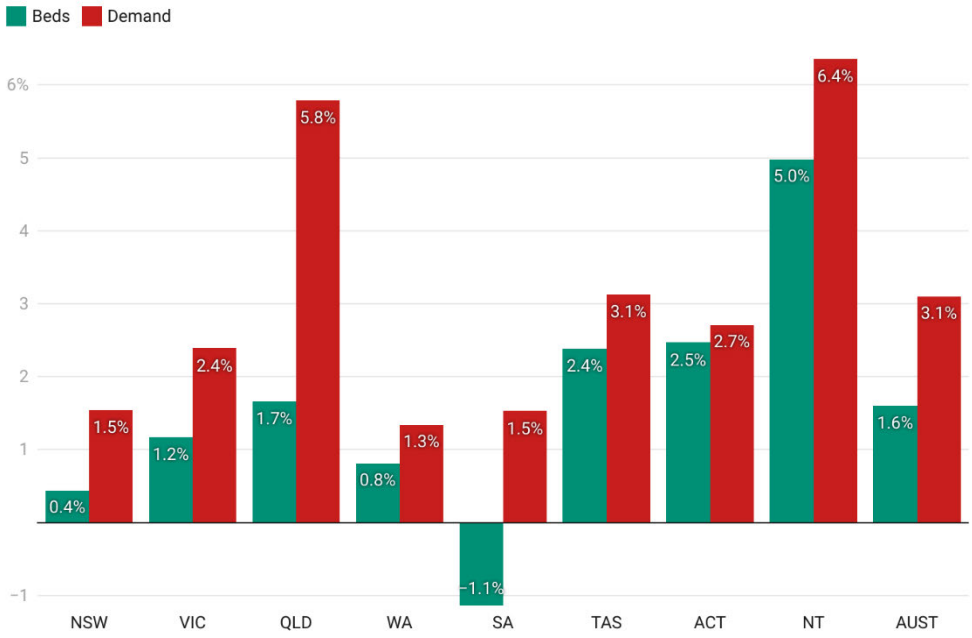
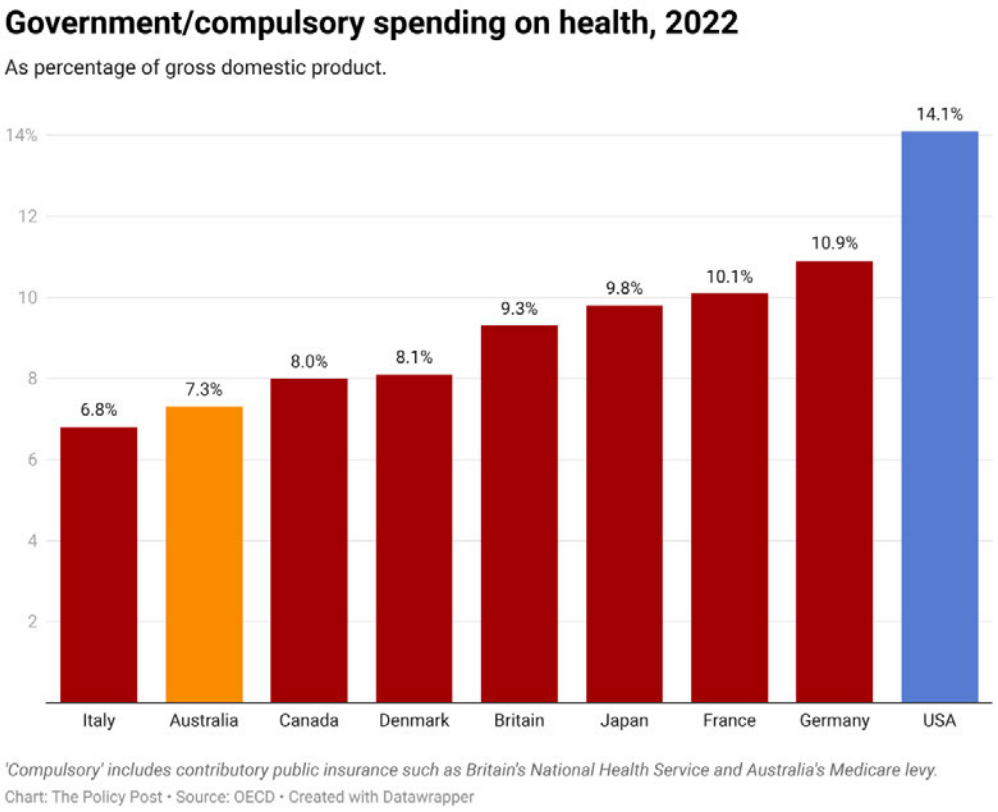


Chart: The Policy Post • Source: AIHW, Hospital Resources; Admitted Patient Care • Created with Datawrapper

The Commonwealth restricts its contribution almost entirely to recurrent expenditure: in 2020-21, the federal government's share of capital costs was 2.2%. This imbalance has resulted in a consistent under-investment in hospital infrastructure around the

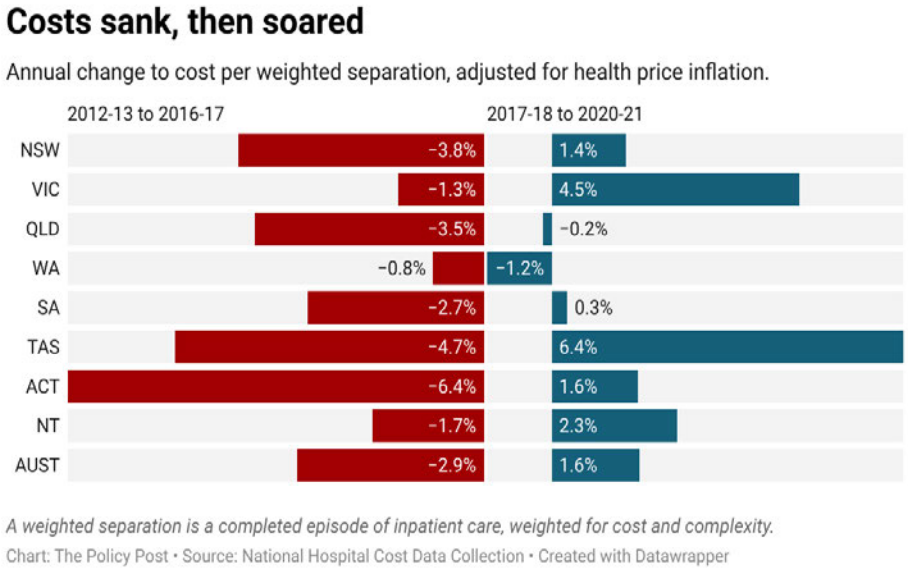
3. *Addendum to national health reform agreement 2020-2025*, Council on Federal Financial Relationships, 2020

country. For at least a decade, increases in the number of inpatients has outstripped the provision of extra beds by two to one. According to the most recent budget, the federal government expects to spend $107 billion on health this financial year.[4] That's a billion dollars every three-and-a-half days, and 16% of the total federal budget. By international standards, though, it's not a lot. In most of the developed nations with which we compare ourselves, governments spend far more.[5]



4. Australian Government, *Budget 2023-23,* Department of the Treasury, May 2023.
5. Organisation for Economic Cooperation and Development, *Health spending,* https://data.oecd.org/healthres/health-spending.htm (accessed 22/8.2023)

For a time, the imbalance between resources and demand produced cost savings. Patients were discharged earlier, staff worked harder, and the failure to invest in infrastructure produced apparently good news for government budgets. Per-patient costs fell.



About five years ago, that all changed. As this chart shows, in the five years up to 2016-17, the cost of treating an average inpatient fell in every state and territory. But then came a turnaround: costs began to surge. The failure to invest in infrastructure is now costing state budgets far more than it saves. All states are now on the same road but the situation is furthest advanced in Tasmania. There, the average cost of treating an inpatient rose by 32% in five years – from $4,604 in 2016-17 to $6,097 in 2020-21.[6] Nationally, the increase was 11% over the same period.

Extra annual cost ($ million) to state budgets				
	2018–19	2019–20	2020-21	3 years
NSW	323	785	729	1,837
VIC	711	1,286	1,716	3,713
QLD	102	592	258	951
WA	-91	-25	-15	-131
SA	174	174	108	456
TAS	102	199	198	499
ACT	10	59	66	135
NT	59	99	150	307
AUST	1,385	3,191	3,255	7,831
Source: National Hospital Cost Data Collection				

As this chart shows, if average per-patient costs had been stabilised at the level of 2016-17, state budgets would have been $7.8 billion better off over a three-year period. The biggest loser was Victoria, where increased costs and high caseloads combined to produce a loss of $3.7 billion over the period.[7] Because the federal government refuses to fund costs above its National Efficient Price, all these extra costs have accrued to state budgets. The price of failing to invest adequately in infrastructure is now very high indeed, and still climbing.

6. Cost per casemix-weighted separation. See *National Hospital Cost Data Collection,* Independent Hospitals and Aged Care Pricing Authority (www.ihpa.gov.au).

7. The Western Australian and Tasmanian results appear here to be better than they really are. In WA's case, which previously had the highest costs in the nation, is now somewhat better but remains less efficient than the national average. Tasmania's costs began to increase three years earlier than in other states.

As recently as 2010, health experts were encouraging governments not to allow average bed occupancy rates to rise beyond about 85%.[8] Rates above that endangered patient safety and meant any surge in demand was destined to produce a crisis. Today, most major hospitals are effectively full. There are no official figures for occupancy rates, but the indirect evidence shows few if any are likely to be below 90% and many are customarily at 100% or higher.

At these levels, few staff can work normally or efficiently. Too much time is spent dealing with rolling crises. A lack of beds on specialist wards causes bed block in emergency departments, as patients needing admission are kept in the ED. They require constant care, diverting nurses and doctors away from dealing with new patients coming through the door. When the ED fills up, patients are kept in ambulances, which cannot then respond to other callouts.

The cost figures for inpatients is an indication of what is going on, but only an indication. The full reality is far worse.

Reform and the National Healthcare Agreement

The hospital system needs two things from the federal government: serious investment in infrastructure; and policy leadership.

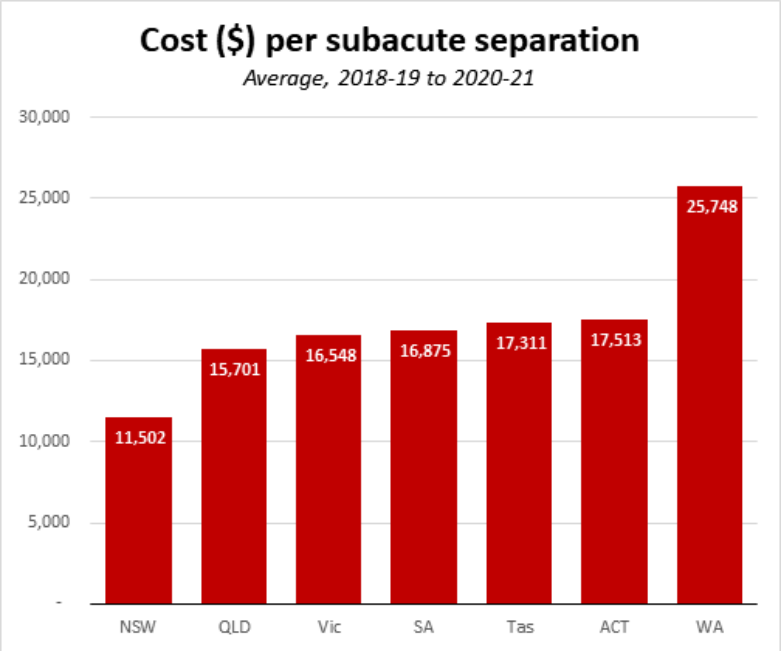
The states have called on the federal government to raise its share of public hospital recurrent funding from 45% to 50% of the National Efficient Price. This was a commitment of the Gillard Labor government's original scheme but was abandoned by the Abbott and Turnbull Liberal governments. This funding level was temporarily achieved during the pandemic but the Albanese Labor government refused to extend it.

Effect of increasing funding to 50% of the NEP ($m)				
2023-24	**2024-25**	**2025-26**	**2026-27**	**Four years**
3,139	3,350	3,544	3,773	**13,805**

If it happened, this would add a little over $3 billion a year to the federal government's contribution to hospital costs.[9] It is needed, but is nowhere near enough. Although it would increase this particular stream of funding by 11%, this increase would comprise only 4.25% of the total cost of public hospitals. And it would continue to ignore the most pressing need in the public hospital system: a more generous – and much more intelligent – approach to infrastructure. In this, only the federal government can supply both the money and the leadership Australia needs to make its public hospitals fit for purpose.

8. Andrew D Keegan, Hospital bed occupancy: more than queuing for a bed, *Medical Journal of Australia,* 196:5, 6 September 2010.
9. Derived from estimates in the 2023-24 budget.

States have tended to concentrate on supplying high-level acute beds – the most expensive of all hospital categories – but have consistently failed to provide a corresponding level of cheaper, more effective alternatives. The result is that far too many people are either accommodated in acute wards when they would be better off elsewhere, or are discharged well before they are able to look after themselves.



In most areas of Australia, there is an urgent need for convalescent facilities, aged care places, hospital-in-the-home, rehabilitation, palliative care, psychogeriatric care and so on. The disparity between states in the provision of such subacute and non-admitted facilities is likely to be a significant element in the massive difference in per-patient costs between jurisdictions.[10]

As part of the forthcoming National Healthcare Agreement 2025-30, the Australian government should negotiate with the states and territories to provide joint matched funding for all forms of hospital infrastructure, including not only the types listed in the previous paragraph but also acute facilities. Such a scheme will need to be well structured, flexible and responsive to local needs. Every area of this country has its own priorities: the agreement should accommodate those differing requirements.

By using matched funding and by becoming a major – and eventually the dominant funder of hospital infrastructure, the Australian government would be able to ensure a level of balance between the various care types that would deliver better and more appropriate care to patients and, in the end, save a great deal of money.

Written by Martyn Goddard, health policy analyst, Hobart

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10. Independent Hospital and Aged Care Pricing Authority, *National Hospital Cost Data Collection,* Rounds 23-25.