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SUBMISSION

TO THE LEGISLATIVE COUNCIL SUB-COMMITTEE ON HEALTH

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INTRODUCTION

The aim of this submission is to provide reliable data on how the Tasmanian public hospital system compares with others across the nation. Because state and federal governments routinely blame each other for shortcomings in the system, it is necessary to drill down into the data to see whether the Tasmanian government provides a level of funding that other states are able to provide, consistent with the public's need and the government's capacity to pay. There are two key issues here: the disparate needs of the populations of each state for hospital services; and the place of GST distribution in allowing states, including Tasmania, to meet those needs.

Any meaningful evaluation of a jurisdiction's performance needs something against which it can be compared: a benchmark. In this case, the rest of the nation provides that benchmark. The GST system of horizontal fiscal equalisation means each jurisdiction has about the same capacity to provide services as any other. This is a basic principle of our federation: that no citizens should receive poorer services than their fellow Australians just because they live in a particular state.

In reaching its decision on GST allocation for Tasmania, the Commonwealth Grants Commission evaluates both the capacity of the state government to raise its own revenue and the greater health needs of the oldest, sickest and poorest population in the country. This submission shows not only that the money allocated to Tasmania to deal with its higher-than-average health needs is not spent; the state government also substantially under-funds its public hospitals, compared with other states, even on a basic *per capita* level.

There are various ways of calculating the amount of this under-spending, as the submission shows. In each, the figures are somewhat different but all confirm the same conclusion.

The submission quantifies the lack of funding and resources by showing the poor performance of Tasmania in providing capacity for our hospitals to do their job. It also shows that in order to provide a level of care comparable to other states, this state would need an extra 300 beds by the end of the next parliamentary term.

Although this document uses national averages as its main benchmark, public hospitals throughout the nation are inadequately resourced; Tasmania's are worse than the average. The inadequacy of the nation's hospitals are principally a result of Commonwealth under-funding; the relative inadequacy of Tasmania's, compared with the others, is the responsibility of the state government.

PLAYING THE BLAME GAME

A term to explain the buck-passing of politicians in health funding – the blame game – has gone into the language. One level of government (the states and territories) routinely blames the other (the Commonwealth) for the shortcomings of their own public hospital system, by saying they are being starved of funds. The response has become almost automatic: the Commonwealth blames the states for lack of efficiency and inadequate state funding. This simple mechanism remains in place regardless of which party is in power, despite attempts to challenge it and in spite of the obvious damage to public confidence in politics, politicians and democracy.

In a more honest world, both would take their own share of the responsibility for the unacceptable state of Australia's public hospitals. The Commonwealth is the only level of government capable of raising enough money to make the system work as it should, yet it consistently refuses to do so. It is well known that unless Commonwealth funding increases dramatically and fairly soon, health costs will overwhelm all state and territory budgets.

On the other hand, the states also have a case to answer. Some jurisdictions – most notably the ACT – are seriously inefficient in their use of money, staff and resources. Queensland and Western Australia are also less efficient than their peers; Tasmania, South Australia and New South Wales are around the average; Victoria is more efficient.[1] But although cost-efficiency has generally improved in recent years, it has often largely (particularly in Tasmania) been as a result of making doctors and nurses work harder, by largely eliminating spare capacity (with implications for safety and the ability to handle peaks) and – as this paper will show – by diverting money away from hospitals into other political priorities.

Data from the Australian Institute of Health and Welfare isolate the various sources of *per capita* health funding by source. The amount of money each state and territory puts of its own money into the day-to-day running of health and hospitals varies greatly. Over a decade, Victoria and Tasmania are consistently at the bottom; the two territories are at the top.

Table 1: Per capita state/local government recurrent health expenditure and national state/territory average, current prices, 2005-06 to 2014-15

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

Source: AIHW, Health Expenditure Australia

[1] National Health Performance Authority: *Cost of acute admitted patients in public hospitals from 2011-12 to 2013-14*, NHPA, Canberra, April 2016.

HEALTH AND THE GST

Health funding is profoundly affected by distribution of the Goods and Services Tax, so a brief aside is necessary here to explain something of how GST redistribution works.

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

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

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

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

Table 2: Health impact of GST distribution, total and per capita, 2004-05 to 2016-17

	NSW		Vic		Qld		WA		SA		Tas		ACT		NT		Redist
	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)	P/cap ($)	Total ($m)
2004-05	-101	-15	-271	-55	28	7	48	24	98	64	40	82	-65	-198	222	1 088	437
2005-06	-63	-9	-301	-60	38	10	30	15	103	67	39	80	-70	-210	224	1 082	434
2006-07	-60	-9	-345	-68	55	14	34	16	92	59	36	73	-67	-198	255	1 209	472
2007-08	-68	-10	-395	-76	84	20	25	12	115	73	41	83	-75	-218	273	1 258	537
2008-09	18	3	-388	-73	15	4	29	13	75	47	43	86	-75	-214	283	1 269	463
2009-10	37	5	-382	-70	-18	-4	25	11	86	53	25	49	-69	-193	296	1 298	469
2010-11	-312	-43	-460	-84	-66	-15	278	120	123	75	106	208	-29	-79	360	1 565	867
2011-12	-519	-71	-667	-119	-15	-3	480	201	145	88	133	260	-31	-84	473	2 030	1 231
2012-13	-697	-95	-640	-113	106	23	504	203	136	82	154	301	-13	-34	448	1 874	1 349
2013-14	-655	-88	-701	-121	32	7	592	233	136	81	172	335	1	3	424	1 745	1 356
2014-15	-658	-86	-816	-138	-2	<1	699	271	109	64	170	330	-10	-26	509	2 086	1 487
2015-16	-531	-69	-987	-164	70	14	557	206	173	102	266	515	-68	-170	518	2 049	1 586
2016-17	-499	-65	-972	-162	74	15	543	201	163	96	251	486	-70	-174	507	2 004	1 638
2017-18	-302	-40	-914	-157	72	15	341	125	157	92	263	509	-77	-143	252	1 941	1 616

Source: Commonwealth Grants Commission

Distribution of the GST makes a major difference to the capacity of all jurisdictions – both those with higher and lesser health needs – to deliver an equal level and quality of care to their people. But that often does not happen. The Grants Commission does not have the constitutional power to direct states to spend GST money in any particular way: as we shall see, some states choose to

spend money allocated to meet health requirements to other priorities. That may be poor and damaging policy, but there is nothing the Commonwealth or anyone else can do. By applying the Grants Commission's weightings to the actual amount of money the states put into health, we can work out how particular states and territories vary their health funding – more or less – from the amount they are allocated.

From Table 3, we can see that while the per capita amount by which the larger and richer states underspend according to their allocated need is relatively small – $141 and $227 respectively – this adds up to a lot of money when the very large populations of those states is taken into account. On this basis, NSW underspent in 2014-15 (according to its assessed need and capacity) by over $1 billion, Victoria by over $1.3 billion and Tasmania by $375 million. Similarly Queensland, Western Australia, South Australia and the two territories spent more.

Overall, though, the underspending in the two largest states plus Tasmania was more than the relative overspend in the others. Overall, the states and territories spent $1.633 billion less than their assessed need and capacity. This money was instead spent on government priorities other than health.

Table 3: State and territory recurrent health funding per capita and total variations from average, 2014-15

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Per capita	1 590	1 431	2 016	2 152	2 069	1 442	2 751	4 470
Variation from av[1]	-187	-346	+239	+375	+292	-335	+974	+2 693
CGC weighting[2]	0.974	0.933	1.004	1.080	1.050	1.221	0.931	1.767
Need per capita[3]	1 731	1 658	1 784	1 919	1 866	2 170	1 654	3 140
Per cap variation v need[4]	-141	-227	+232	+233	+203	-728	+1 097	+1 330
Total var v av ($'000)[5]	-1 067 113	-1 337 281	+1 101 550	+599 475	+343 372	-375 175	+425 489	+323 109

1: The amount each state varies from national average per capita health funding.
2: Commonwealth Grants Commission weighting for state health funding.
3: Amount each jurisdiction would spend if population share and CGC weightings were both applied: the assessed requirement for health spending.
4: Amount of money needed to achieve (3), compared with the amount actually spent.
5: The amount of money (in millions) by which each jurisdiction varies from the assessed requirement.
Sources: AIHW Health Expenditure Australia, 2014-15; Commonwealth Grants Commission 2015 Review; ABS Australian Demographic Statistics.

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

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

The generosity of GST health funding for Tasmania has increased markedly over the period. Once every five years, the Grants Commission conducts a complete review of its methods; in the 2004 Review, it recognised the need for specific attention to differing health needs across the country. Tasmania benefited significantly. In 2010, the Commission calculated that far more redistribution was needed. Tasmania benefited still more, with its health-specific GST allocation jumping from $25 million in 2009-10 to $106 million in 2010-11. In its 2015 Review the state's treatment was even more generous, jumping from $170 million in 2014-15 to $251 million in 2016-17.

Figure 1: Recurrent under- and over-spending, including health-specific GST funding, states and territories, 2014-15

Despite what the state government claims, this is a solid funding stream. It can be relied upon. The excuse that it is too volatile to be put into health funding is not valid.

As Table 4 shows, in the decade to 2015-16 the Tasmanian government spent on health almost $950 million dollars less than the average of all state and territory governments of its own money, not counting the money raised from patients or Commonwealth contributions. In only one year, 2010-11, did it spend more; but this was massively reversed in the years since then by both the Labor-Green and the Liberal government.

During the same decade, the amount of GST grew sharply. As we can see, none of this money – which is meant to increase the capacity of the state government to fund health services *from its own resources*, was never spent on health; and only in one year was any of it spent on health at all. Over the period, over $1.2 billion was allocated to the state in health-specific GST money; less than $80 million of this was ever spent on the purpose for which it was given.

If the Tasmanian government had spent from its own resources (including the GST) as much as the average of all states, almost $2.2 billion extra would have flowed into health services. This is a clear measure of the extent the state's health system has fallen behind the rest of the nation over a decade.

Table 4: Recurrent health under-spending by the Tasmanian government ($'000), years ending June 2006 to 2016

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

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

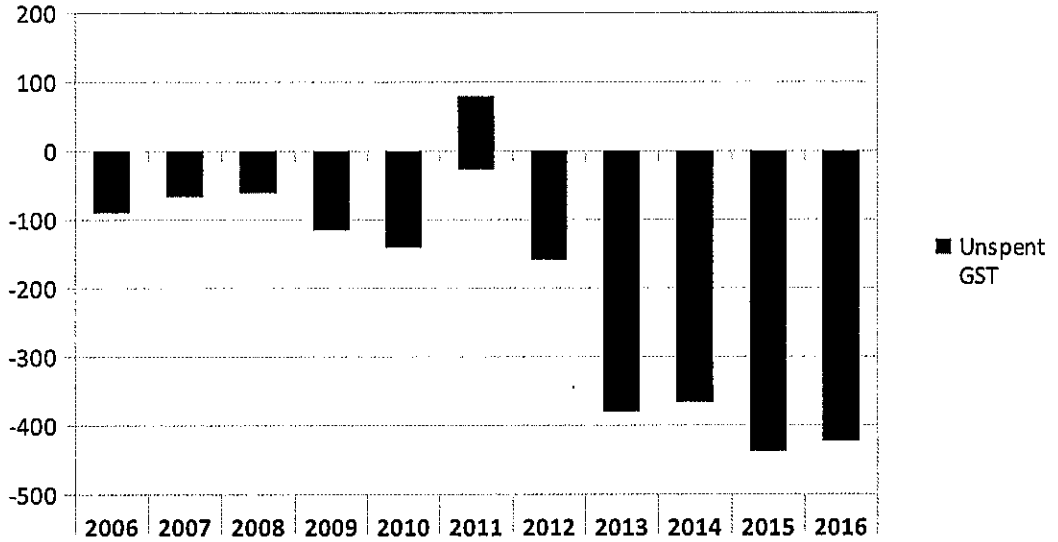
(b) The amount of health-specific GST funding received by Tasmania.

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

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

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

Figure 2: Recurrent health under-spending ($ million) by the Tasmanian government, population adjusted, years ending June 2006 to 2016



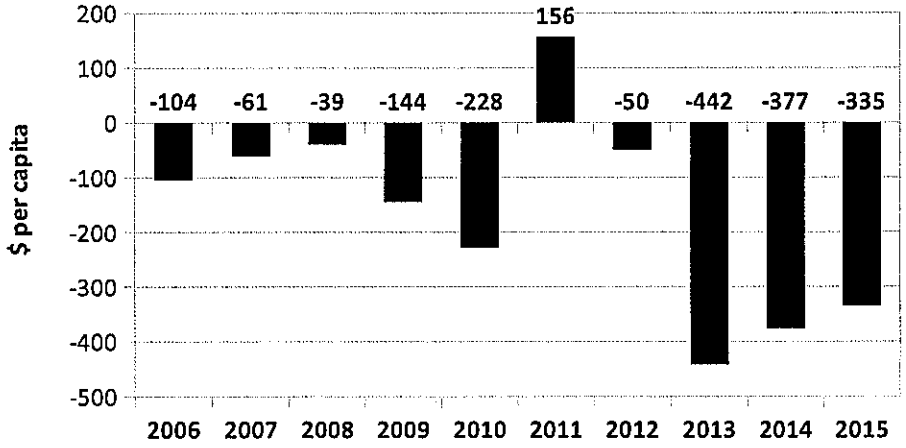
Of this, $861 million has been in the first two years of the Hodgman Liberal government. The combined effect of the rise in health-specific GST allocations and state budget cuts means the performance of the present government is far worse even than its predecessor.

Table 5: State/local government recurrent health expenditure, total and per capita, current prices, 2005-06 to 2014-15

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

Source: AIHW, Australian Health Expenditure

Figure 3: Tasmanian government recurrent health funding, variation from national average ($ per capita), years ending June 2006 to 2015



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

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

Table 6: Per capita state/local government health expenditure and national state/territory average, current prices, 2005-06 to 2014-15

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

Source: AIHW, Health Expenditure Australia

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

MAKING PATIENTS PAY

There are two ways for hospitals to respond to inadequate funding from government. One is to get money from someone else, such as the patient. The other is to become more efficient. Most hospital systems are doing both.

The most common way by which Australia's 'free' public hospitals raise extra money is through charging patients. This is done indirectly (through private health insurance, accident insurance and workers' compensation) or directly (through fees such as those demanded by outpatient pharmacies). This is part of an increasing trend by state and federal governments to shift costs from their own budgets onto those of individuals. The hospital changes need to be seen against a background of large and rising health care costs in a formerly free and universal system.

Recurrent funding raised by state public hospitals from non-government sources in 2014-15 was $4.862 billion, about 10% of the total. Of this, almost $1.5 billion came from patients through private health insurance and a further $1.5 billion through direct patient charges. The rest came from a variety of sources including workers' compensation and third-party accident insurance.

Table 7: Non-government recurrent funding of public hospitals ($ million) including Commonwealth private insurance subsidy, states and territories, 2014-15

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PHI receipts	520	237	137	66	59	25	14	3	**1 061**
PHI subsidy	211	96	56	27	24	10	6	1	**431**
Total PHI	*731*	*333*	*193*	*93*	*83*	*35*	*20*	*4*	***1 492***
Individuals	272	469	326	339	48	19	4	8	**1 485**
Other non-govt	821	323	481	40	165	28	9	18	**1 885**
TOTAL	**1 824**	**1 125**	**1 000**	**472**	**296**	**82**	**33**	**30**	**4 862**

Source: AIHW Health Expenditure Australia 2014-15

Grants Commission assessments do not take into account varying levels of efficiency in the state health systems. Data from the National Health Performance Authority show that technical cost efficiency – that is, the cost of each admitted patient service weighted for cost and complexity – is the lowest in Victoria and the highest in the ACT.[2] Queensland, Western Australia and South Australia tend to be less efficient than the average; New South Wales and Tasmania are generally on the average.

The extent to which each state relies on admitted patients paying for their treatment through their private health insurance is shown here:

[2] NPHA/AIHW, *Financial performance: Efficiency of public hospitals*, www.myhospitals,gov.au, accessed 3 January 2017.

Table 8: Separations by principal source of funding, public hospitals, states and territories, 2015-16

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Total separations	**1 861 163**	**1 669 562**	**1 293 125**	**630 739**	**438 831**	**122 604**	**108 041**	**148 416**
Public patients (n)	1 412 863	1 402 623	1 097 188	562 306	385 800	92 434	91 504	141 602
Public patients (%)	*76%*	*84%*	*85%*	*89%*	*88%*	*75%*	*85%*	*95%*
PHI (n)	370 369	214 329	158 815	53 420	37 885	21 523	11 857	3 704
PHI (%)	*20%*	*13%*	*12%*	*8%*	*9%*	*18%*	*11%*	*2%*
Self-funded (n)	24 486	9 584	10 393	724	1 067	18	6	643
Self-funded (%)	*1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*
Workers' comp (n)	7 469	5 376	5 544	1 474	1 180	432	480	467
Workers' comp (%)	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*
Accident ins (n)	7 670	9 466	4 337	2 406	2 852	763	280	320
Accident ins (%)	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*
DVA (n) [(a)]	35 206	17 022	15 439	5 124	6 752	2 209	2 625	631
DVA (%)	*2%*	*1%*	*1%*	*<1%*	*1%*	*2%*	*2%*	*<1%*
Other (n) [(b)]	3 100	11 162	1 409	5 285	3 295	5 225	1 289	1049
Other (%)	*<1%*	*<1%*	*<1%*	*<1%*	*<1%*	*4%*	*1%*	*<1%*

Totals may not add due to rounding.
(a) Department of Veterans' Affairs
(b) 'Other' includes Department of Defence, correctional facilities, other hospital or public authority.
Source: AIHW, Admitted patient care 2015-16

The table above shows that Tasmania has the nation's lowest proportion of public hospital inpatients being treated as public: 75% against a national average of 83%. The rest are funded with money the patients themselves bring into the hospital: from their private and other insurance, rights to treatment by the Department of Veterans Affairs, and so on.

In reaching its budgetary claims about health and hospital funding, the state government includes this revenue as part of its payment to the Tasmanian Health Service. The budget figures must therefore be interpreted carefully, with this in mind.

Over the past decade, the proportion of private patients being treated in public hospitals has greatly increased in all states. Although NSW has the highest proportion of patients funded through private insurance, Tasmania comes second in this category; overall, when all non-government categories are included, this state's public hospitals have the highest proportion of private patients in the nation. The effect on Tasmanians needing hospital care is magnified by the state's population mix of older, sicker and poorer people: those who, in other words, are most reliant on the public system and least capable of paying for private insurance or private treatment. Increasingly, the state's public hospitals are turning into government-owned private hospitals instead. As such, their ability to treat the needs of Tasmanian people is substantially reduced and the fundamental idea of universal health care – that people are treated according to their need, not to what they can afford – is increasingly being abandoned.

The following table shows relative cost weights for all state and territory hospital systems. Cost weights are the means by which the system of activity-based (or casemix) funding calculates how much money each separation should receive. The system is based on allocating each condition to a Diagnosis Related Group (DRG), of which there are several thousand. A DRG with a cost weighted as 1.0 attracts the basic National Efficient Price from the Commonwealth, which this year is $4,883. A more complex and costly condition (or DRG) with a cost-weighting of 2.0 would therefore attract $9,176; for one with a weighting of 0.5, the payment would be $2,294.

Average cost weights also give us an insight into the relative complexity of cases being treated in a hospital system. Tasmania's average cost weight for 2015-16, at 1.02 was the highest in the country,

and 10% above the national average. This indicates that our hospitals are disproportionately treating more complex, sicker patients than the rest of the country. Although Tasmanians on average need more health care than other Australians, there is no evidence that our population as a whole has a higher *proportion* of complex cases. The most likely explanation for this state's high average cost weight is that hospitals are unable to treat everyone and tend to concentrate on the sickest and most urgent cases.

Table 9: Cost weights, by principal source of funding, public hospitals, states and territories, 2015-16

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Public patients	**0.97**	**0.91**	**0.92**	**0.87**	**0.98**	**1.02**	**1.00**	**0.92**	**0.92**
PHI	1.05	1.00	0.93	1.30	1.30	0.94	0.86	1.08	1.04
Self-funded	1.26	0.78	1.11	0.83	0.81	0.94	1.67	1.00	1.11
Workers' comp	1.14	1.29	1.19	1.47	1.14	1.19	0.99	1.14	1.21
Accident ins	1.51	2.06	1.59	2.93	1.91	2.24	2.44	2.19	1.91
DVA [(a)]	1.23	1.17	0.98	1.42	1.14	1.14	0.88	0.70	1.16
Other [(b)]	1.06	1.21	1.07	1.15	1.16	1.10	1.02	0.61	1.13

(a) Department of Veterans' Affairs
(b) 'Other' includes Department of Defence, correctional facilities, other hospital or public authority.
Sources: AIHW, Admitted patient care 2015-16.

Elective surgery patients in public hospitals who are funded by their own private insurance experience waiting times of less than half of those who are treated as public patients. Although these figures are not given by state and territory, there is no reason to suppose the picture does not occur in all jurisdictions, particularly in those, like NSW and Tasmania, with very high rates of private insurance funding in their public hospitals. The reason for this has not been researched but a likely cause is that hospital surgeons with rights of private practice favour their own patients over those from the public list. These private patients are therefore able to jump the queue, lengthening the waiting times of public patients even more.

Table 10: Waiting times for elective surgery patients, public hospitals, by principal source of funding, Australia, 2015-16

Funding source	Admissions	Days waited at 50th percentile	Days waited at 90th percentile	Waited longer than 365 days
Public patients	609 999	42	273	2.0%
Private health ins	47 033	20	107	0.8%
Self-funded	14 701	16	72	0.1%
Workers' comp	1 764	6	69	0.3%
Third party accident	1 595	13	91	0.8%
DVA[(a)]	1 833	20	93	0.3%
Other[(b)]	3 166	187	632	31.3%
TOTAL	680 091	**38**	**263**	**2.0%**

(a) Department of Veterans' Affairs.
(b) 'Other' includes Department of Defence, correctional facilities, other hospital or public authority.
Sources: AIHW, Admitted patient care 2015-16.

How Funding Affects Performance

Relative levels of efficiency go some of the way toward explaining the capacity of some hospital systems to treat more patients than their state government funding would suggest. That state's treatment of overnight separations is below the average but same-day separations are well above. Converting overnight or multi-night patient stays into same-day treatment is a major way of improving cost-effectiveness. In Tasmania, the effect of serious under-funding is clear in the separation statistics. Far fewer inpatients are treated in this state than in any other jurisdiction.

Table 11: Raw separations per 1,000 population, states and territories, 2014-15

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
Overnight	121.1	107.9	115.0	106.4	119.0	100.1	124.1	189.7	**115.1**
Variation from average	*+6.0*	*-7.2*	*-0.1*	*-8.7*	*+3.9*	*-15.0*	*+9.0*	*+74.6*	
Same-day	101.5	147.0	131.7	124.6	106.6	108.2	143.1	408.3	**125.1**
Variation from average	*-23.6*	*+21.9*	*+6.6*	*-0.5*	*-18.5*	*-16.9*	*+18.0*	*+283.2*	
Total	222.6	254.9	246.7	231.0	225.6	203.3	267.2	598.0	**240.2**
Variation from average	*-17.6*	*+14.7*	*+6.5*	*-9.2*	*-14.6*	*-36.9*	*+27.0*	*+357.8*	

Source: AIHW, Admitted patient care 2014-15

A comparison of the most recent two years for which comparable data are available once more shows Tasmania has fallen further behind the rest of the nation. Though the gap between Tasmania and the rest of the nation in same-day separations became a little smaller, it was still the second-worst result. But for overnight and multi-day patients, the gap worsened substantially.

Table 12: Raw separations per 1,000 population, states and territories, 2015-16

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
Overnight	122.2	111.0	118.9	109.8	121.0	104.7	132.5	202.0	**117.8**
Variation from average	*+4.4*	*-7.8*	*-1.1*	*-8.0*	*+3.2*	*-13.1*	*+14.7*	*84.2*	
Same-day	102.5	151.4	141.3	128.0	111.2	107.3	147.6	465.0	**129.7**
Variation from average	*-27.2*	*+21.7*	*+11.6*	*-1.7*	*-18.5*	*-22.4*	*17.9*	*+335.3*	
Total	224.7	262.4	260.2	237.8	232.2	212.0	280.1	666.9	**247.5**
Variation from average	*-22.8*	*+14.9*	*+12.7*	*-9.7*	*-15.3*	*-35.5*	*+32.6*	*+419.4*	

Source: AIHW, Admitted patient care 2015-16

The number of patient days (that is, one patient for one day) is another clear measure of some hospital systems dealing better with inadequate funding than others. Although the Queensland and South Australian state governments fund their hospitals at more than the national average, the number of patient days in these states is below the national average. In both New South Wales and Victoria, this indicator is somewhat above the average.

Tasmanian hospitals, despite improvements in efficiency and raising money from patients, remains firmly at the bottom of the heap, providing far less adequate care than other states – even though its older, sicker and poorer population requires a higher-than-average level of care.

Table 13: Patient days per 1,000 population, public hospitals, states and territories, 2014-15

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
Patient days per 1,000 pop	792.2	758.2	719.9	693.6	768.8	659.8	915.8	1 615.0	**763.5**
Variation from crude avg	+28.7	-5.3	-43.6	-69.9	+5.3	-103.7	+152.3	+851.5	-
CGC weighting	1.009	0.972	0.990	0.998	1.038	1.091	0.907	1.292	**1.000**
Patient days for weighted avg	770.4	742.1	755.9	762.0	792.5	833.0	692.5	986.4	**763.5**
Variation from weighted avg (n)	+21.8	+16.1	-36.0	-68.4	-23.7	-173.2	+223.3	+628.6	-
Variation from weighted avg (%)	+2.8%	+2.2%	-4.8%	-9.0%	-3.0%	-20.8%	+32.2%	+63.7%	-

Source: AIHW, Admitted patient care 2014-15; Commonwealth Grants Commission 2015 Review.

In 2014-15, Tasmanian public hospitals delivered 20.8% fewer patient days than would have been needed to deliver the same level of care to Tasmanians as the rest of the nation. This higher level of care was funded through extra GST payments but was not provided. A year later, in 2015-16, the situation had worsened. The number of patient days per 1,000 population deteriorated further, both in crude average and weighted average terms. The weighted percentage fell further, from 20.8% below the national average to 21.7% below. As these figures show, no other state delivers anywhere near such low levels of admitted patient care to its people.

Table 14: Patient days per 1,000 population, public hospitals, states and territories, 2015-16

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
Patient days per 1,000 pop	790.6	761.9	818.9	690.3	771.8	669.4	930.9	1 600.1	**783.4**
Variation from crude avg	+7.2	-21.5	+35.5	-93.1	-11.6	-114.0	+147.5	+816.7	-
CGC weighting	1.009	0.972	0.990	0.998	1.038	1.091	0.907	1.292	**1.000**
Patient days for weighted avg	790.5	761.5	775.6	781.8	813.2	854.7	710.5	1 013.0	-
Variation from weighted avg (n)	-0.1	-0.4	+43.3	-91.5	-41.4	-185.3	+220.4	+587.1	-
Variation from weighted avg (%)	na	na	+5.6%	-11.7%	-5.0%	-21.7%	+31.0%	+58.0%	

Source: AIHW, Admitted patient care 2015-16; Commonwealth Grants Commission 2015 Review.

Waiting times for elective surgery are problematic in most major Australian hospitals but are by far the longest in Tasmania. The data for the state's four main hospitals are given here, compared with the national peer-group average for each hospital.

Table 15: Percentage of elective surgery patients treated within the recommended time, four main Tasmanian hospitals, 2015-16.

	RHH		LGH		NWRH		Mersey	
	Hospital	Peer av	Hospital	Peer av	Hospital	Peer av	Hospital	Peer av
Urgent (30 days)	69	96	82	97	87	97	93	99
Semi-urgent (90 days)	35	84	39	87	61	87	73	92
Non-urgent (365 days)	68	93	50	92	81	92	74	96

Source: AIHW, myhospitals.gov.au, Elective surgery waiting times.

These statewide average figures disguise some specialties in some hospitals, particularly the RHH and LGH, in which the waiting times are very long indeed. For the Royal Hobart Hospital, the proportion of patients waiting longer than 365 days in 2015-16 include 22% for cholecystectomy[3] (against an average of peer-group hospitals of 1.8%); 21.2% for hysterectomy (2.8%), 34% for inguinal herniorrhaphy[4] (5.2%), 35.3% for septoplasty[5] (11.5%), 20.3% for general surgery (2.2%),

[3] Gall bladder removal.
[4] Surgical repair of a hernia in the groin.
[5] Surgical correction of the nasal septum.

18.1% for gynaecology (1.8%) and 11.3% for plastic surgery (2.4%).[6] The government has since moved to treat more long-wait patients in some areas, particularly those awaiting cataract excision, hip replacement and colonoscopy. None of the areas listed in this paragraph are likely to have been significantly affected by this.

We need also to take into account the time prospective patients must wait for their first consultation with a specialist. They are not put onto a surgical waiting list until that happens. This is often known as 'the waiting list to get on the waiting list'. The most recent indicative data for clinic waiting times are given for the Royal Hobart Hospital in the following table:

Table 16: Outpatient clinics, Royal Hobart Hospital, waiting times (days) at 70th percentile for first consultation 24 July 2017

Clinic name	*Urgent*	*Semi-urgent*	*Non-urgent*
Audiometry	376	787	844
Cardiology	47	74	88
Colorectal	47	207	1168
Colposcopy	96	54	63
Dermatology	118	125	31
Diabetic	137	97	194
Ear, nose & throat	61	1 084	1 515
ENT paediatric	76	374	
Endocrinology	38	80	220
Gastroenterology & liver	759	1 063	1 384
General medical	75	39	13
General surgery	59	73	293
Gynaecology	62	94	301
Infectious diseases	49	32	26
Inflammatory spinal		145	124
Neurology	47	167	315
Neurosurgery	286	1 236	1 589
Nutrition & dietetics	157	521	404
Ophthalmology	77	131	328
Oral & maxillofacial	24	75	62
Orthopaedic	28	440	754
Osteoarthritis pathway		87	
Paediatric continence			144
Paediatrics medicine	32	13	144
Paediatrics surgery	26		55
Plastic	39	217	318
Renal	40	74	110
Respiratory	28	56	67
Rheumatology	125	258	945
Spinal assessment	47	398	754
Thyroid	56	63	130
Urology	35	136	159
Vascular	55	59	67
Wound		46	105

Source: DHHS

[6] AIHW, (myhospitals.gov.au), *Elective surgery waiting times.*

Another key indicator of public hospital performance is bed block, where patients needing to be admitted to a specialist ward have to remain in emergency for extended periods because no bed can be found for them. This is serious in two ways. First, it contributes enormously to the workload of emergency staff, takes up physical capacity needed by other patients, causes ambulance ramping and bypass, and prevents staff from dealing as they otherwise would with less urgent patients. Second, it is dangerous to patients. Table 17 shows the median time taken between presentation and either discharge or transfer to a ward: that means, half of all patients waited for less time and half for longer.

Table 17: Emergency department median lengths of stay (hours: minutes) states and territories, 2015-16

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

Data for the ACT were not reported.
Source: AIHW, Emergency department care.

But as Table 18 shows, that difference escalates dramatically when we look at the 90th percentile – that is, when 10% of patients have spent this time or longer in emergency. Nationally, we see that the difference between the two groups has gone from under two hours to almost six hours. The most probable principal cause of this difference is bed block. Once again, inadequate funding by the Tasmanian government puts this state's system at the bottom of the performance table.

Table 18: Emergency department lengths of stay (hours: minutes) at 90th percentile, states and territories, 2015-16

	NSW	Vic	Qld	WA	SA	Tas	NT	Aust
Patients admitted	11:50	11.00	8.50	8.17	10:53	19:24	15:56	**10:43**
Patients not admitted	4:53	5:22	4:45	4:49	5:38	5:21	5:04	**5:01**
All presentations	6:52	7:19	6:18	6:03	7:31	8:41	9:27	**6:53**

Data for the ACT were not reported.
Source: AIHW, Emergency department care.

Both internationally and in Australia, it is estimated that patients affected by bed block have a relative mortality risk between 20% and 30% greater than those who are not so affected. In 2006, drawing on data from 2002-03, Australian researchers found that the number of avoidable annual deaths caused by ED overcrowding was around 1,500 a year nationally, a number greater than the road toll.[7,8,9,10]

Since then, the number of patients presenting at Australian hospitals has greatly increased and bed block in Tasmanian hospitals is about twice as bad as in the country as a whole, and is likely to be significantly worse even than that at the Royal Hobart Hospital. Extrapolating from the 2002-03

[7] DB Richardson, D Mountain, Myths versus facts in emergency department overcrowding and access block, *Medical Journal of Australia,* 6 April 2009.
[8] DB Chalofin, S Trzeciak, A Likourezos, Impact of delayed transfer of critically ill patients from the emergency department to the intensive care unit, *Critical Care Medicine,* 2009.
[9] PC Spiruvilis, J-A Da Silva, IG Jacobs et al, The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments, *Medical Journal of Australia,* 2006.
[10] DB Richardson, Increase in patient mortality at 10 days associated with emergency department overcrowding, *Medical Journal of Australia,* 2006.

data gives us an approximate figure of 120 to 130 avoidable deaths from bed block in Tasmania each year; some 70 to 80 of these are likely to occur at the Royal Hobart Hospital.

Some broad-brush data on a limited number of markers of relative safety and quality of admitted care are reported. Most of these are available only on a state-wide basis and do not reveal what is happening in a hospital that is, like the Royal Hobart, under particular pressure. They also pre-date the current decanting process at the RHH.

These figures show Tasmania's performance is well below the national average in most categories. The measure of complications arising during care needs some explanation: a certain level of unforeseen complications is inevitable but high rates indicate problems with the care itself.

Table 19: Percentage of separations with a condition arising during the episode of care, public hospitals, states and territories, 2015-16

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Same-day	0.8	1.0	1.1	0.7	1.9	1.3	1.8	0.4	1.0
Overnight	16.2	27.7	19.9	19.5	19.8	22.5	22.5	13.0	20.4
Total	9.2	12.3	9.6	9.4	11.2	11.5	11.7	4.1	10.2

Source: AIHW, Admitted patient care, 2015-16

Rates of unplanned readmissions are subject to the same caveat. Some are unavoidable; too many indicate something is likely to be going wrong.

Table 20: Unplanned/unexpected readmissions within 28 days for selected surgical procedures, rate per 1,000 separations, public hospitals, states and territories, 2015-16

	NSW	Vic	Qld	WA	SA	Tas	Aust
Appendicectomy	18.8	19.3	20.3	32.5	34.1	35.0	20.9
Cataract extraction	2.7	2.8	4.6	1.6	2.6	8.8	3.2
Hip replacement	17.3	19.1	20.0	21.9	20.9	39.0	19.2
Hysterectomy	38.3	25.9	35.0	42.9	33.6	36.3	33.4
Knee replacement	19.5	19.3	31.4	23.3	27.5	36.4	23.1
Prostatectomy	23.6	20.7	42.3	40.4	29.2	10.5	26.5
Tonsillectomy	27.1	23.9	56.7	53.7	52.3	46.0	34.7

The ACT and the Northern Territory have been excluded because of low numbers.
Source: AIHW, Admitted patient care, 2015-16.

Falls are another indicator of inadequate patient care, often arising from overcrowding. It should be noted that patients who are sicker and more frail are more likely to suffer falls; patient care must adapt to this. Lower-income patients are also more likely to suffer falls; this may also impact on Tasmania's falls rate.

Table 21: Separations for falls resulting in patient harm, per 1,000 separations, public hospitals, states and territories, 2015-16

NSW	Vic	Qld	WA	SA	Tas	Aust
5.8	3.4	3.9	5.0	5.4	6.7	4.6

The ACT and the Northern Territory have been excluded because of low numbers.
Source: AIHW, Admitted patient care, 2015-16.

The statistics on hospital-acquired *Staphylococcus aureus* show clearly what happened when a rigorous program of hand-washing was introduced at the Royal Hobart Hospital. Rates of *S. aureus*

infection went from 1.39 per 10,000 bed days to 0.65 in a year. Similar improvements were not seen in the state's other main hospitals. It should be noted that small numbers at the NWRH and the Mersey result in volatility in the data: we need to look at the broader picture over the six years.

Table 22: Rates of hospital-acquired *Staphylococcus aureus* infection per 10,000 bed days, major Tasmanian hospitals, 2010-11 to 2015-16

	RHH		*LGH*		*NWRH*		*Mersey*	
	Hospital	***Peer av***	***Hospital***	***Peer av***	***Hospital***	***Peer av***	***Hospital***	***Peer av***
2010-11	1.39	1.68	1.16	1.06	0.55	1.06	1.61	0.69
2011-12	0.65	1.44	0.93	0.94	1.18	0.94	1.37	0.47
2012-13	0.88	1.38	1.51	0.99	0.30	0.99	0.46	0.59
2013-14	0.93	1.34	1.11	0.86	1.67	0.86	0.92	0.48
2014-15	0.60	1.14	1.06	0.79	0.74	0.79	1.74	0.44
2015-16	0.86	1.02	1.27	0.72	1.74	0.72	1.35	0.51

Source: AIHW/National Hospital Performance Authority, my.hospitals.gov.au, Healthcare-associated S. aureus bloodstream infections.

FUNDING AND BED NUMBERS

Perhaps the clearest evidence of whether or not a state's people are being short-changed by their government's health funding, relative to other states, is in the number of beds provided in public hospitals. But we also need to know whether the differing needs of each state's population are appropriately reflected.

To do this, we must first look at how many beds each jurisdiction has. This is seen in row (c) in the following table. Row (d) shows how many beds each state has above or below the population-adjusted national average.

But this does not show us how many beds are needed in each jurisdiction if they are to deliver the same standard of care around the nation, given the different needs of each population. Because of Tasmania's older, poorer and sicker population, the Commonwealth Grants Commission calculates the state needs 1.091 times as much to be spent on admitted patient care as the nation as a whole, and uses this needs-based weighting to deliver commensurately more GST money to the state. If we apply this weighting to bed numbers, it means Tasmania in 2015-16 would have needed about 130 more beds than it had to be able to deliver a national-standard of care to its population.

Table 23: Average available public hospital bed numbers by state and territory and numbers needed for equal allocation by population share, 2015-16

	NSW	Vic	Qld	WA	SA	Tas[h]	ACT	NT	Aust
Beds per 1,000 pop[a]	2.78	2.41	2.51	2.16	2.82	2.54	2.83	2.72	2.56
Population ('000) [b]	7 627	6 033	4 784	2 544	1 702	515	397	245	23 851
Current bed numbers[c]	21 203	14 540	12 008	5 495	4 800	1 308	1 124	666	
Beds needed for nat av[d]	19 525	15 444	12 247	6 513	4 357	1 318	1 016	627	
Beds +/- nat average[e]	-1 678	+904	+239	+1 018	-443	+10	-108	-39	
CGC weighting[f]	1.009	0.972	0.990	0.998	1.038	1.091	0.907	1.292	1.000
Beds for weighted average[g]	19 701	15 012	12 125	6 500	4 523	1 438	922	810	
Beds +/- for weighted average	+1 502	+472	-122	-13	-277	+130	-292	+144	

(a) The average number of available beds per 1,000 population in each jurisdiction.
(b) Population at June 2015.
(c) Current bed numbers, based on AIHW estimate of the number of beds per 1,000 population. This may vary from
(d) The number of beds which each jurisdiction would have if the national average applied across the country.
(e) The number of beds in each jurisdiction above or below the national population-adjusted average.
(f) Commonwealth Grants Commission relative weighting for admitted care, reflecting disparate needs of each population.
(g) The number of beds each jurisdiction would require if the national population-adjusted average also reflected CGC weightings: this is a measure of the bed numbers required in each jurisdiction in order to provide an equal standard of care across the nation.
(h) The AIHW notes that in 2014-15 Tasmania reclassified a number of mental-health aged care and same-day beds. This change increased the reported number of beds in the state by 103 but did not involve actual new beds. In its calculations of the number of beds per 1,000 population (on which this table is based) the Institute adjusted for this change to produce figures which are more comparable across the country.
Sources: AIHW, Australian Hospital Statistics (Hospital Resources 2014-15); ABS, Australian Demographic Statistics; Commonwealth Grants Commission, 2015 Review.

These figures are out of date as soon as they are compiled. Particularly, they do not take into account the needs of hospital systems into the future. Table 18 below shows the likely need for additional beds in Tasmanian public hospitals over the period from 2015-16 to the end of the next state parliamentary term in 2021-22. Using the five-year average annual increase in patient days (3.2%) we can see that the number of beds to supply that demand will increase substantially over

the period. By the end of the next parliamentary term, Tasmania's need for beds will increase by about 299 above what it ought to have had in 2015-16. Because the state needed an extra 130 beds in 2015-16, it means that 429 beds above the 2015-16 figure would need to be delivered if Tasmanians are by that time to receive the same level of care as other Australians.

Table 24: Beds needed in Tasmanian public hospitals to achieve and maintain the 2015-16 national average, 2015-16 to 2021-22

	2015-16	*2016-17*	*2017-18*	*2018-19*	*2019-20*	*2020-21*	*2021-22*
% increase yoy	-	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
Beds needed	1 438	1 484	1 531	1 580	1 631	1 683	1 737
Beds increase yoy		46	47	49	51	52	54

Sources: AIHW, Australian Hospital Statistics (Hospital Resources 2014-15); ABS Australian Demographic Statistics; Commonwealth Grants Commission, 2015 Review.

Even this figure under-estimates the need: it does not take account of where the beds currently are or what use is being made of some of them. Apart from its four main hospitals, Tasmania has another 19 small public hospitals, including 13 with 10 beds or fewer. In 2015-16, those 19 small hospitals accounted for 242 of the state's beds. On the basis of the limited information publicly available, it is clear that average occupancy rates for these small hospitals are typically around about 60%, with some as low as 30%. This means that over 100 beds of the state total are unused on an average day, in massive contrast to the situation at the Royal Hobart and Launceston General Hospitals. If these smaller hospitals are not to be rationalised, the pressing need for resources at the LGH and RHH means that the figures in Tables 23 and 24 represent significant under-estimates of real needs.