

State of Health 2018

An analysis of the adequacy of public
hospital services in Tasmania

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Executive summary

Patients are waiting too long for services and the needs of staff aren't being met. Tasmanians have been let down by a system which is broken.

Michael Ferguson, Minister for Health, 26 July 2014.

THIS report draws on a large range of official data, mostly from the Australian Institute of Health and Welfare and the Australian Bureau of Statistics, to provide an account of how the public hospital care available to Tasmanians compares with that in the nation as a whole. In all major categories, Tasmanian public hospitals have the least capability to meet the needs of the population.

Although the state government receives many hundreds of millions of dollars in additional GST entitlements in recognition of the health and hospital requirements of the population, this money has not been spent on health. Instead, it has been diverted to other budgetary uses to which the government has assigned a higher priority. Since it came to power in March 2014, the government has diverted \$1.6 billion in this way, or about 35% of its total health budget.

The data, when examined in a coherent way, show why Tasmanian public hospitals are in a state of unrelenting crisis. It also provides clues about what now needs to be done to repair a system that the Health Minister, when first appointed over four years ago, described as broken.

Oldest, poorest, sickest

Only the Northern Territory, because of its high indigenous population, has a greater need for health services than Tasmania. This state's demographic is of a generally older population than any other state, and one with the lowest levels of income and wealth. These characteristics are closely associated both with poorer health and, by definition, less capacity to pay for necessary health care.

The average age of people in Hobart in 2016 was 39.7 years, higher than any other capital and 4 years higher than Sydney and Melbourne. Life expectancy at birth for males in Tasmania was 78.8 and 82.9 for females; the national average was 80.4 and 84.6 respectively. Median weekly income and average household assets were substantially below any other state.

Health status was much worse, with 19% describing their health as only fair or poor, against 14.8% for the nation. Tasmania has the highest death rate and the second highest rate of infant mortality of any state.

For all these reasons, Tasmanians need much more health care than other Australians. As this report shows, they get far less.

The money

Per-capita state government recurrent (day-to-day) health expenditure for the three years 2014-15 to 2016-17 was 15.2% lower in Tasmania than in Australia as a whole. Capital investment was 38.4% lower.

About 46% of Tasmania's public hospital running costs are funded from the state government's health budget. Commonwealth activity-based funding provides about 45% of the cost of each patient. Other money comes from various Commonwealth programs, private health insurance, workers' compensation and accident insurance. A few patients pay for themselves.

Low spending on hospitals by the state government means fewer patients can be treated. In turn, this attracts less Commonwealth activity-based funding. Because the Commonwealth and the states share the cost of treating each patient almost equally, the effect of low state expenditure in reducing the Commonwealth contribution doubles the problem.

The impact of state under-funding is further exacerbated by the diversion away from health of hundreds of millions of dollars a year in GST funding that is redistributed from other states and allocated to Tasmania in recognition of this state's higher health care needs.

The Commonwealth Grants Commission, which administers the GST, works in two main stages. First, it redistributes money between the states so each jurisdiction – which have different capacities to raise money themselves – has an equal per capita amount to spend on services. But despite this, as we have seen, the Tasmanian government spends much less than the average on health.

The second stage looks at the relative health needs of each population. In this stage, Tasmania currently receives about \$260 million a year, redistributed from other states which have lower levels of need. If the state government actually spent this money on health, per-capita expenditure would be much higher than the national average; but it is much lower.

To see how much health-related GST is being diverted from health into other government priorities, we must add together the two figures. **This shows the Hodgman government has under-funded the state's health system by around \$1.6 billion since being elected in March 2014, compared with the amount the Commonwealth Grants Commission has calculated needs to be spent to give Tasmanians the same standard and level of care as other Australians.**

Public hospitals, private patients

In 2016-17, 22% of all Tasmanian public hospital inpatients were treated as private patients and funded by their private health insurance. The rate has been growing strongly for many years and is highest at the Royal Hobart Hospital. It occurs under a scheme that gives some senior doctors – mainly surgeons and anaesthetists – the 'right of private practice' to boost their incomes.

The pressure for higher incomes derives from the amounts some senior clinicians can get in the private sector – in more than a few cases, this is over \$1 million a year and up to \$3 million or more. Public hospital doctors working under the Medical Practitioners Award have a ceiling on earnings of around \$300,000.

Under the Commonwealth-state health funding agreements, patients have the right to be treated as private in public hospitals and, as private patients, to be given the right to choose their own doctors. This choice is not given to public patients.

Special units within each major hospital are employed by the Private Practice Scheme, which functions as a semi-autonomous administration-within-an-administration. Its employees, rather than nurses or other hospital staff, encourage patients with private insurance to join the scheme and sign them up.

On average, participating doctors receive about 95% of the income from private insurance, with only 5% going to the hospital to pay for the whole of that patient's care except the doctors' fees. The Tasmanian Health Service also misses out on Commonwealth activity-based funding, normally 45% of the cost of any patient's care. The federal government's rationale for this is that it has already contributed 27% of the cost of private insurance premiums.

According to an authoritative internal estimate, each patient treated under the Private Practice Scheme involves a loss to the hospital of an average of \$1,500, compared with treating the same patient as public. Overall, this involves an annual loss to the state's public hospitals of about \$38 million.

The pressures: admitted patients

Tasmanian public hospital care is both the most inadequate and the least safe in the country. It follows from the low rate of overall health funding that fewer patients can be treated. The rate of separations (completed episodes of inpatient care) is the lowest, at 213 per 1,000 population against 245.9 for the nation as a whole, a difference of 13.38%.

The rate of patient days shows an even starker picture: 636.2 per 1,000 population in Tasmania against 750.4 for Australia, a shortfall of 15.22%.

Average cost weights, which measure the average complexity and cost of cases, is the highest in the country: 1.07 against 0.97 for the nation. This shows that hospitals, unable to treat everyone, are forced to choose the most urgent, complex and therefore costly cases. If the mix of cases was at the level of average complexity that statisticians would expect, there would be a cost weight of 1.

Over the five years to 2016-17, the admissions at the Royal Hobart Hospital increased by 18.09% and at the Launceston General Hospital by 36.88%. The difference between the hospitals shows that the RHH became full before the LGH; but neither hospital can realistically accept a greater workload than it does now without a major and immediate increase in staffing and resources.

Mental health admissions over the five year period rose by 75% at the LGH and, at the RHH – at a time when psychiatric beds were being reduced – by 51%.

The number of beds has grown at about one-third the rate of patients, leading to a shortfall in beds of 281 statewide over the five years. This has continued in the 16 months since then. The estimated current figure is that Tasmanian public hospitals would need another 350 fully-staffed and available beds to regain the capability they had in 2011 before a long series of budget cuts began.

The increasing pressure on staff and existing resources is having a predictable effect on safety and quality. On the three currently available measures which compare states – readmissions, falls and unforeseen complications, the care offered by Tasmania's public hospitals is the nation's least safe and of the poorest quality.

The pressures: emergency

Unlike other areas of a hospital, emergency departments cannot ration their treatment. They have no control over how many people walk through the door. So it is here that the failure of resources to keep up with demand is most clearly seen.

In Tasmania, the bulk of pressure on EDs has occurred in the two main hospitals, and particularly the RHH. The overall number of presentations rose by 30.78% from 2010-11 (the year before major budget cuts were introduced) to 2016-17. Most of the increased

demand was in more complex and demanding cases: emergency presentations rose by 44.06%, urgent by 29.78% and semi-urgent by 37.17%. In contrast, non-urgent cases stayed away, a strong indication that increased workload is not being driven by GP-type cases.

At the LGH there was a similar, though less pronounced, trend. A major difference was the large increases at both ends of the triage hierarchy: resuscitation and emergency, and non-urgent.

In the two north-western hospitals, workload tended to remain stable, showing none of the major increase in demand seen in the two larger institutions.

Although bed block – where patients have to remain in the ED because there is no room on a ward – is a serious problem in all states, it is worse in Tasmania than elsewhere. Again, it is the two major hospitals which bear the brunt.

The standard measure of bed block is the time waited in ED by patients needing admission at the 90th percentile – that is, when 90% have been admitted and 10% are still waiting.

In 2016-17 bed block at the RHH was the third-worst of all 30 major hospitals in its national peer group (16 hours 59 minutes waited at the 90th percentile); the LGH was worst among the 29 major regional hospitals (22 hours 38 minutes); time waited at the NWRH was 21st longest of 29 large regional hospitals (14 hours 19 minutes); and at the MCH was 17th longest of 21 medium regional hospitals (10 hours 34 minutes).

Overall, the LGH had the worst bed block of any of the 287 public hospitals in Australia with emergency departments. And only eight had a worse result than the RHH. Staff at both hospitals attest that the situation has continued to deteriorate in the past year.

Australian and overseas research has shown that bed block (which in Australia is defined as patients needing admission waiting in emergency for eight hours or longer) involves an increased relative risk of death of 30%. ***It is therefore likely that there are in excess of 80 premature deaths a year in Tasmanian hospitals because of emergency department bed block.***

The pressures: elective surgery

Elective surgery is defined as any procedure which can be delayed by at least 24 hours. Three broad urgency levels have been developed. The most serious need their procedures within 30 days; the next urgent, within 90 days; and the least urgent within a year. Ideally, no patient should have to wait for longer than this.

In Tasmanian public hospitals, many do. Although the national averages for each of the hospital peer groups vary, all of this state's four main hospitals fall below either the clinically recommended guidelines and the performance of similar hospitals around the country.

In terms of the time patients have to wait for their operation after being placed on the elective surgery waiting list, Tasmania once again has the worst results in the nation. The extent of this is partly revealed in the following table. The time waited at the 90th percentile level – where 90% of patients have been admitted and 10% are still waiting – is much longer than the nation as a whole, though on this measure NSW is even worse. But Tasmanian patients are almost four times as likely to have to wait for longer than a year for their surgery than the national average.

But this tells only half of the story of elective surgery waiting times. The other half is the time people have to wait, after a referral by their GP, for an initial consultation with a

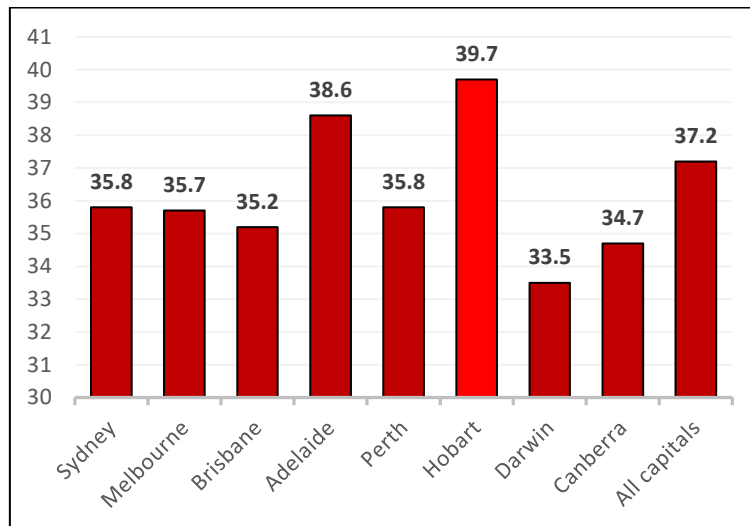
surgeon. Only then will their names be put on the official elective surgery waiting list. That is why clinic waiting times are known as 'the waiting list to get on the waiting list'. This can extend by many months or even years the time people needing surgery have to wait for their operation. These times are longest at state's main hospital. At the RHH, the 75th percentile waiting time for even the most urgent categories in paediatric ear, nose and throat and neurosurgery – can be almost a year, with 25% waiting even longer. For non-urgent cases of adult with ear, nose and throat problems the figure is five years and three months; for children in this category it is almost three years. In neurosurgery, semi-urgent cases also have to wait for almost three years to get on the official waiting list with, again, 25% waiting longer. For non-urgent neurosurgery patients, the figure is five years and four months.

Oldest, poorest, sickest

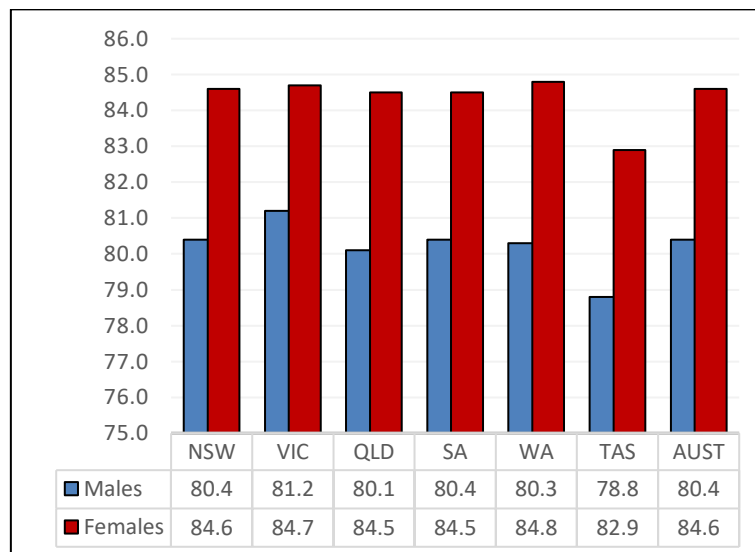
ANY population's need for health services is closely related to age, wealth and general state of health. On all these measures, Tasmanians fare worse than people in any other Australian jurisdiction. Therefore, the state needs more and better health services, on a per-capita basis, than anywhere else. As the evidence shows, though, what it has is the opposite of what it needs. Tasmania has the least capable health system in the country. The inability of public hospitals, particularly, to meet demand is an ongoing and ever-deepening scandal.

The first indicators, age and life expectancy, are shown here. The territories are not comparable with the states on these measures: the Northern Territory because of its atypically high indigenous population; and the ACT because many people from southern NSW are treated in Canberra, skewing the data.

Average age of population in capital cities, 2016¹



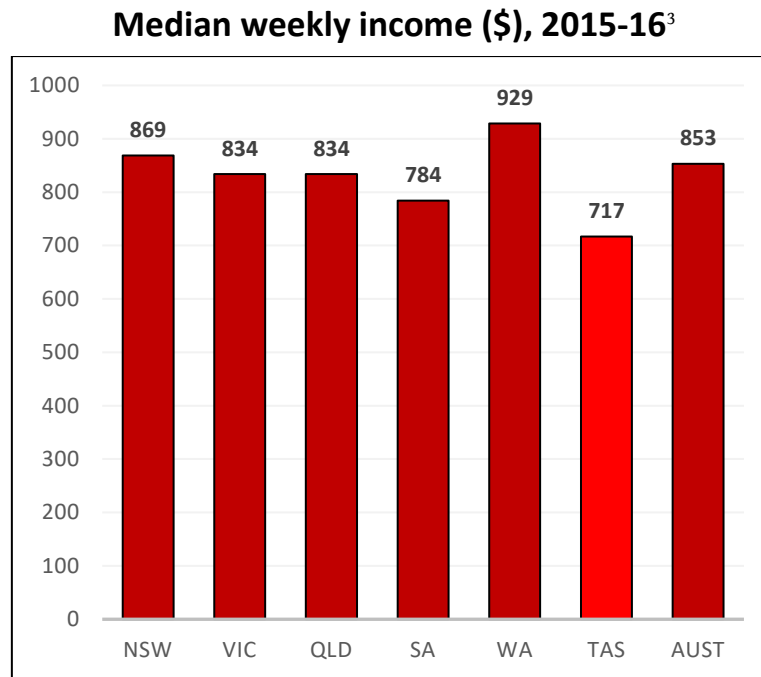
Life expectancy at birth, 2014-16²



1. ABS Cat 3235.0 - Population by Age and Sex, Regions of Australia, 2016.

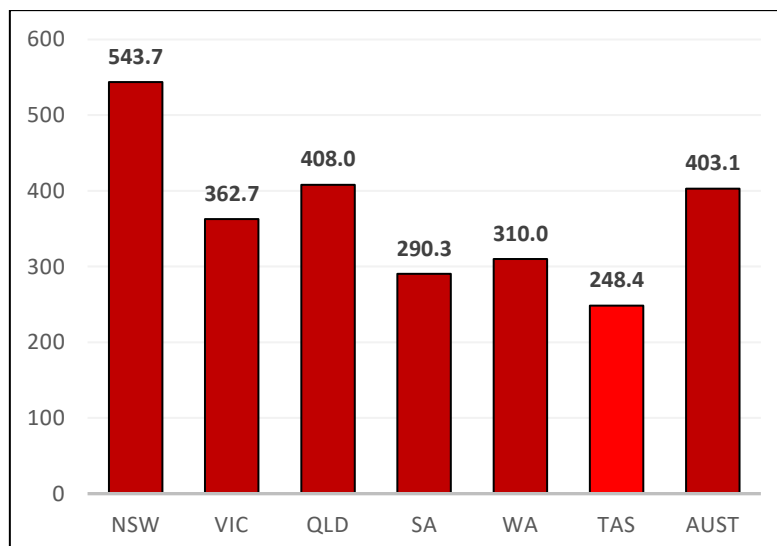
2. ABS Cat 3302.0.55.001 - Life Tables, States, Territories and Australia, 2014-2016.

Only the Northern Territory, with its very high indigenous population, has worse life expectancy than Tasmania. And as the following chart shows, average income in Tasmania is the lowest in the nation.



When we look at average wealth, a similar picture emerges. The chart below shows average household financial assets, a measure which excludes variation due to different dwelling values around the nation.

Average (mean) household financial assets (\$'000), 2015-16⁴

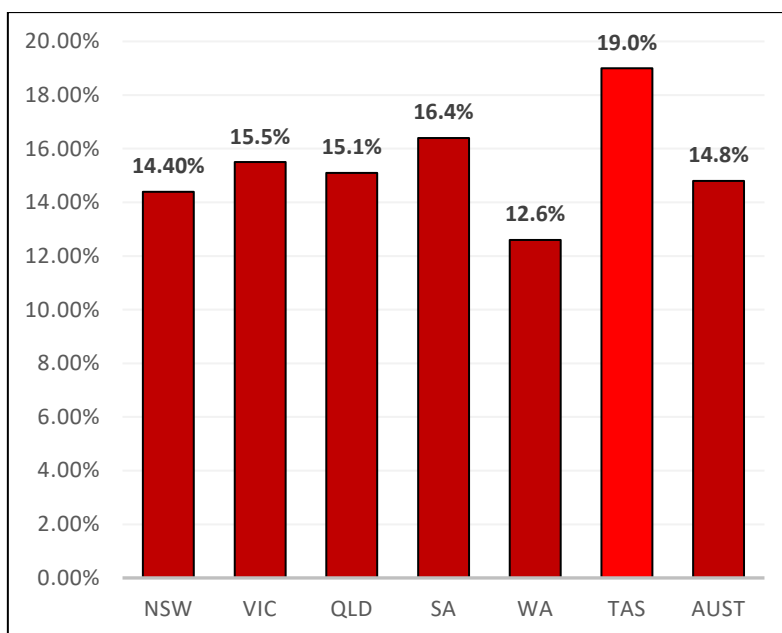


A far greater proportion of Tasmanians, compared with other states, describe their general health status as only 'fair' or poor'.

3. ABS Cat 201516, Household Income and Wealth, Australia: Summary of Results, 2015-16.

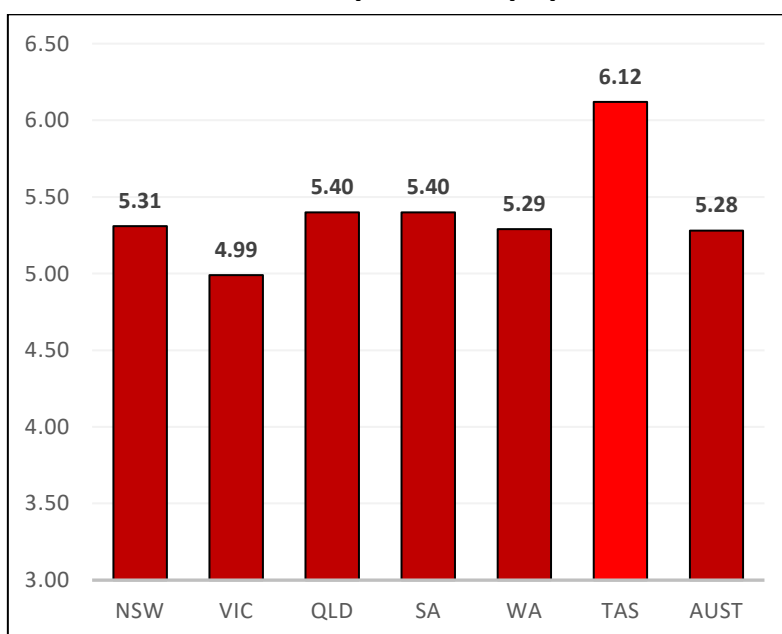
4. *ibid.*

Health status assessed as 'fair' or 'poor', percentage of persons, 2014-15⁵



The list of health conditions in which Tasmania leads every other jurisdiction in the nation is impressive: arthritis, asthma, back problems, chronic obstructive pulmonary disease, deafness, cardio-vascular disease, hypertension, kidney disease, long-sightedness, mental health problems, severe or very severe pain and high or very high psychological distress. The state has the highest levels of obesity and, after the Northern Territory, the second-highest levels of daily smoking and alcohol consumption.⁶ It also has the highest death rate ...

Standardised death rate per 1,000 population, 2016-17⁷

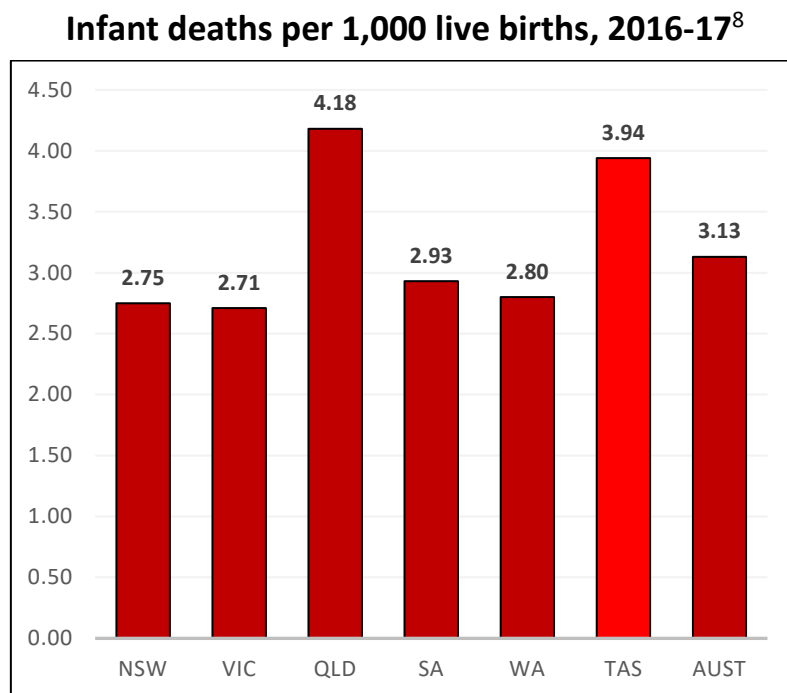


5. ABS National Health Survey, 2014-15.

6. *ibid.*

7. ABS Cat 3010.0, Australian Demographic Statistics, March 2018. The standardised death rate is weighted to negate age differentials between the states.

... and the second highest level of infant mortality of any state.



Because as much as 20% of lifetime health costs accrue in the last three years of life, a high death rate has significant implications for public hospitals. Tasmania, has 2.1% of Australia's population and 3% of its deaths. That amounts to about an extra 1,000 deaths a year, each costing of the order of \$30,000 each.

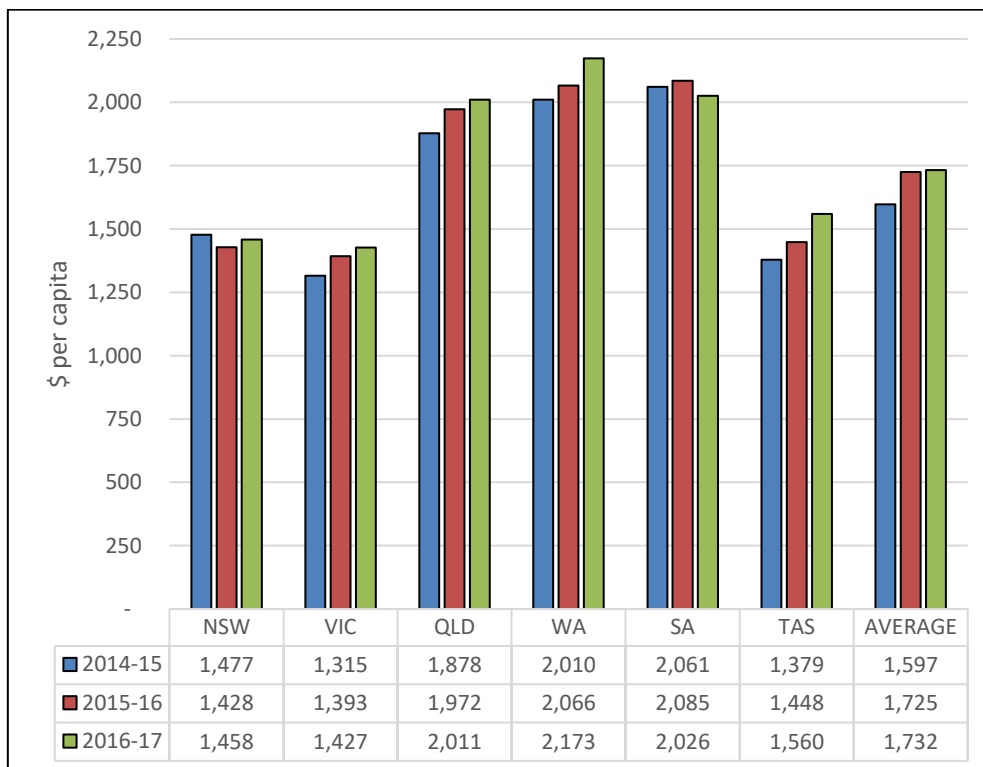
8. *ibid.*

The money

Because Tasmania’s population has the highest health needs of any state, the state government’s funding of public health services needs to be comparably higher. This is not the case. For many years, Tasmanian governments have spent much less, on a population-adjusted basis, than the average of other states. As the following chart shows, Tasmanian government health funding is barely more than that in New South Wales or Victoria, whose people are younger, healthier and richer and who therefore need much less health care than Tasmanians.

The following two charts show the impact of the budget cuts which occurred early in the term of the present state government. Although there has been some increase since then, funding remains significantly lower than the average even though the Tasmanian health system needs much more than the average in order to deliver a national standard of care.

**Recurrent state government health expenditure per capita,
2014-15 to 2016-17**



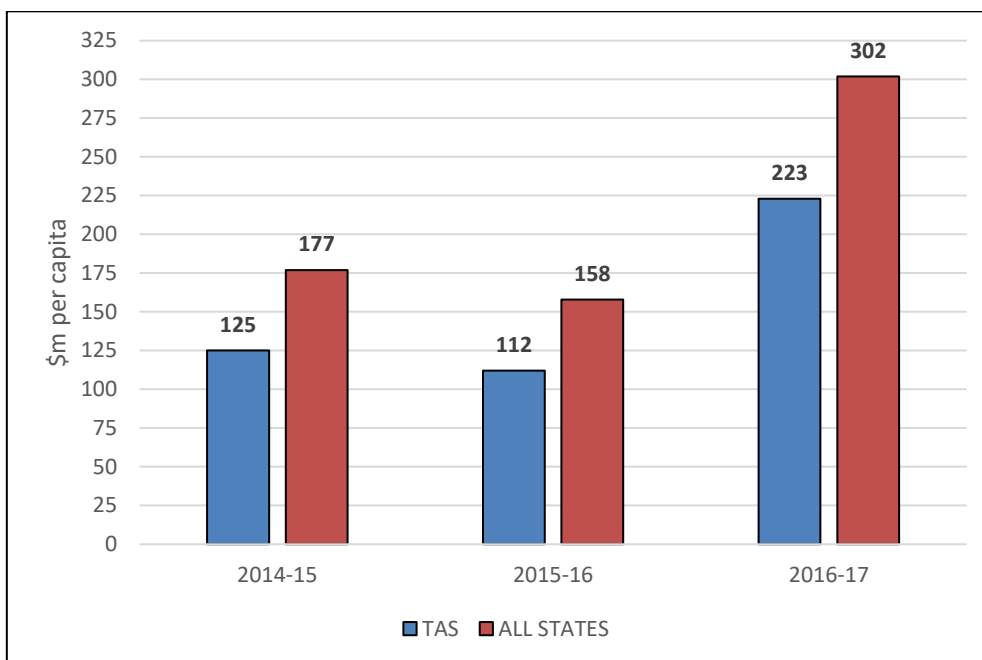
The territories are not comparable with the states on these measures: the Northern Territory because of its atypically high indigenous population; and the ACT because many people from southern NSW are treated in Canberra, skewing the data.

Source: AIHW, Health expenditure Australia.

Over the three years, the Tasmanian government’s day-to-day recurrent expenditure on its health service was \$667 million less than the national average.

Even though the redevelopment of a building at the Royal Hobart Hospital means capital expenditure over the three years has been higher than is usually the case, there was also a shortfall in capital spending. Over the three years, this was \$176 million less than the national average.

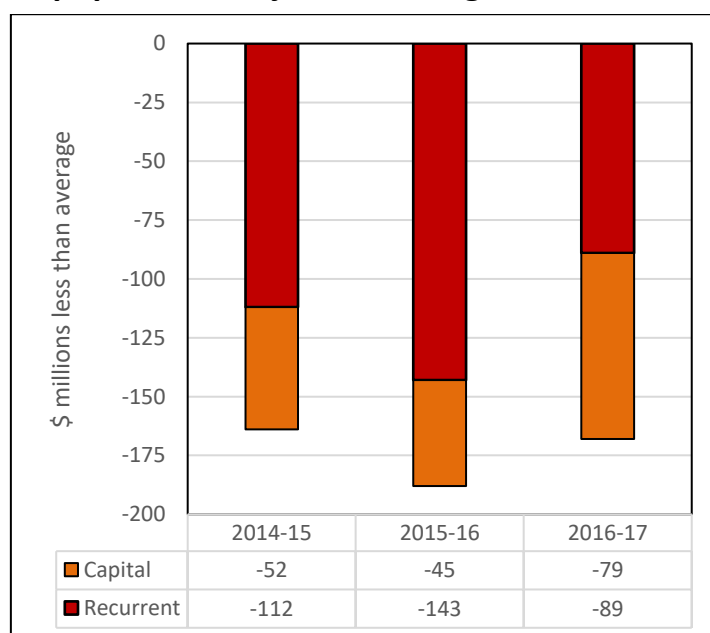
State government capital expenditure on health (\$m), Tasmania and all jurisdictions, 2014-15 to 2016-17



Source: AIHW, Health expenditure Australia.

When capital and recurrent spending is put together, the complete picture emerges the extent of Tasmania’s under-funding of its health system.

Amount (\$m) of Tasmanian government health expenditure less than national population-adjusted average, 2014-15 to 2016-17



Source: AIHW, Health expenditure Australia.

Though state publicly-funded health systems comprise much more than hospitals – community nursing, health promotion, public health, community mental health, and so on – hospitals take the majority of health funding in any jurisdiction.

About 46% of Tasmania’s public hospital running costs are funded from the state government’s health budget. Commonwealth activity-based funding provides about 45% of the cost of each patient. Other money comes from various Commonwealth programs, private health insurance, workers’ compensation and accident insurance. A few patients pay for themselves.

Public hospital expenditure by funding source, Tasmania, 2016-17

C’wealth	State	Total govt	HIF*	Individuals	Other	Non-govt	Total
\$593m	\$556m	\$1,149m	\$37m	\$16m	\$26m	\$69m	\$1,217m
48.73%	45.69%	94.41%	3.04%	1.31%	2.14%	5.67%	100%

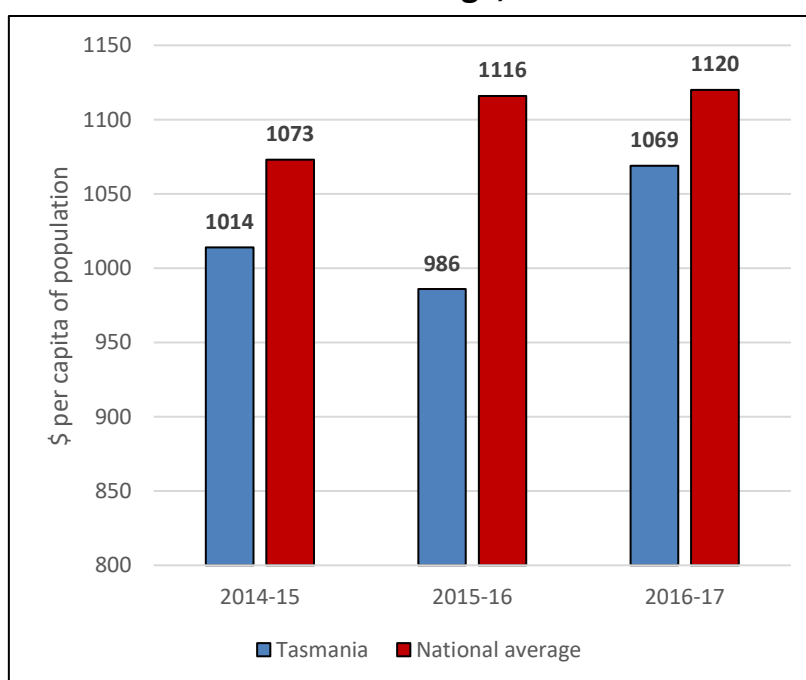
*Health insurance funds. Includes Commonwealth premium rebates.

Source: AIHW, Health expenditure Australia 2016-17.

Activity-based funding is just that: if fewer patients are treated, there is less money from Canberra. Low state government funding, therefore has a magnified effect on overall hospital budgets and on their capacity to treat patients.

Over the three years to 2016-17, the Tasmanian government spent \$123.5 million dollars less than the national population-adjusted average on its public hospitals. This is far more damaging than it seems at first sight: a great deal of Commonwealth funding is foregone. It should also be remembered that the Tasmanian population needs much more health care than the national average. All levels of funding should, therefore, be much higher than the average and not, as is the case, lower. Because of its higher GST entitlement, the state government has the money available to meet this need. It has chosen not to do so.

State government recurrent funding of public hospitals, Tasmania and national average, 2014-15 to 2016-17



Source: AIHW, Health expenditure Australia.

The GST system ensures all states and territory governments have an equal capacity to deliver services to their people, despite great variations between the jurisdictions in both the capacity to raise money and in the needs of specific services such as health.

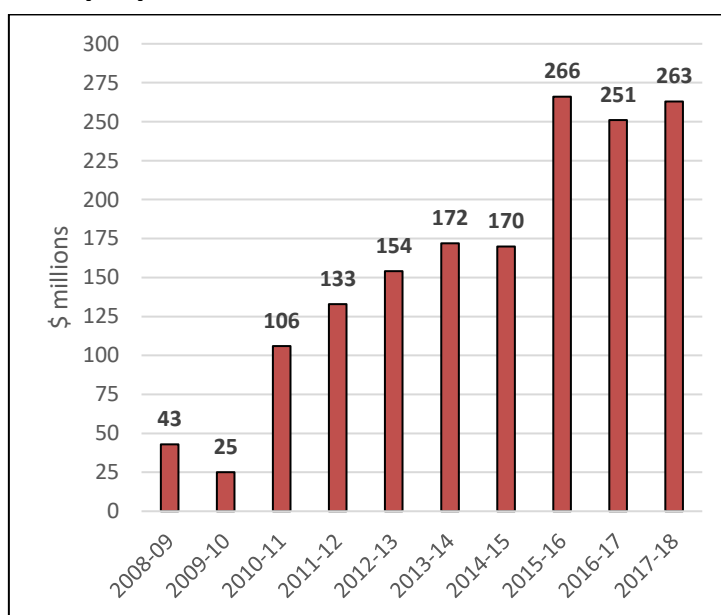
It is called horizontal fiscal equalisation. In order to achieve this, the Commonwealth Grants Commission works in two main stages. The first is to bring all states and territory governments up or down to give them the same per capita budgetary capacity, regardless of how much money they can raise themselves.

The second is to look at their relative needs in service areas – health, schools, justice, roads and so on. The process of calculating this need is complex but provides by far the most comprehensive and reliable measure of funding requirements that is available anywhere in Australia. Tasmania does very well in both of these calculations. The Commission calculates the level of need for health service funding in each jurisdiction and redistributes GST money between them to ensure all governments are able to provide an equal standard of service, taking into account their varied needs. This is in addition to the first stage of fiscal equalisation.

The Commission began looking at health needs in 2008-09, when Tasmania was granted an extra \$43 million, redistributed from other states. In each of its major five-year reviews since then, the Commission has further refined its calculations and each time Tasmania has been allocated more than before. Paradoxically, each of these two large increases in GST allocation coincided with major state government cuts to health budgets.

In 2011-12 the Giddings government, concerned about whether it had enough money and fearful of lower GST allocations, savagely cut its health budget. In the following two years public hospitals lost 21% of doctors and 12% of nurses.⁹ But by the time these cuts were announced, the government was already receiving massively health-specific top-up GST money that took the amount from \$25 million in 2009-10 to \$106 million in 2010-11 and \$172 million by 2013-14, when the Labor-Green government lost office.

Health-specific top-up GST allocations for Tasmania, 2004-05 to 2017-18



Source: Commonwealth Grants Commission.

9. AIHW, Hospital resources 2014-15. These positions were on a full-time equivalent basis. Because these losses could not be sustained, the need for locums, agency nurses and overtime drove the cost of each remaining FTE doctor up by 32% and each FTE nurse by 12%.

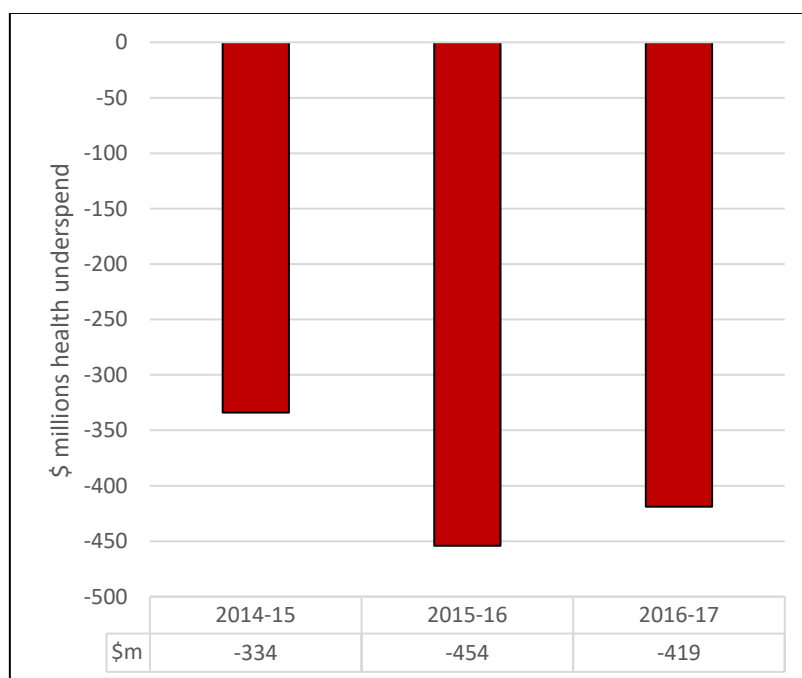
When the Hodgman Liberal government assumed office in March 2014, another round of cuts was initiated. Again, these were accompanied by a further rise in GST allocation for health – from \$170 million in 2014-15 to \$266 million in 2015-16. But the cuts went ahead and none of this money was spent on health. Instead, it continued to be diverted into other budgetary areas to which the government had given higher priority.

This health top-up money, allocated in recognition of Tasmania’s *above-average* need for health services, is in addition to the first stage of GST grants that ensure each state has the same *average* per capita amount to spend on its operations. As we have seen, Tasmania under-spends substantially in this area as well.

To understand the total effect of both categories of under-spending on the health system, we need to add both together. As we can see in the following chart, the Tasmanian government would have had to spend \$1.207 billion more on health to be able to deliver what the Grants Commission calculates to be a national average standard of care in Tasmania.

Comparative figures for 2017-18 are not yet available. But if we assume that the relative under-spend in 2017-18 was about the same as in the year before, we can see that the Hodgman government under-funded the state’s health system by around \$1.625 billion in its first term of office.

**Total amount of health-related GST not spent on health (\$m),
Tasmania, 2014-15 to 2016-17**



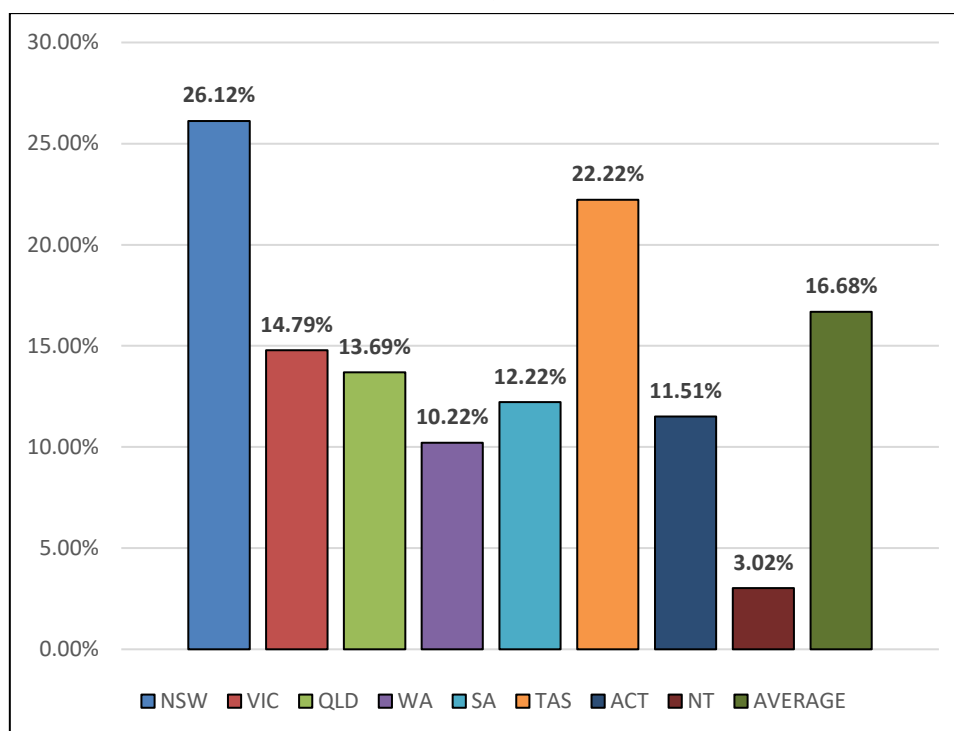
Source: AIHW, Health expenditure Australia.

Under the Intergovernmental Agreement on Federal Financial Relations, GST allocations are treated as a ‘general purpose grant’ rather than a ‘specific purpose payment’. The Commonwealth can direct states to spend specific purpose payments in particular ways – for instance, school payments must be spent on school and activity-based health payments must be spent on patients. But the use of general purpose grants are at the state or territory government’s discretion. The Tasmanian government, then, is breaking no laws by diverting health GST to other purposes. But because it *can* do this does not imply that it *should*.

Public hospitals, private patients

IN Tasmania, 22% of all separations – that is, completed episodes of inpatient care – are for private patients funded by their private health insurance. This system provides a windfall for a minority of senior doctors – mostly surgeons and anaesthetists – but comes at a serious cost to other patients and to the public hospitals themselves.

Percentage of admitted public hospital patients (separations) funded with private insurance, 2016-17



Source: AIHW, Admitted patient care 2016-17

The system is complex and little-understood, and has two apparently unrelated causes. One is the desire by doctors to match the very high incomes they believe they could get in the private system. The other is a Byzantine structure of federal regulation that has unforeseen and highly negative impacts on state public hospitals.

Because there so few countervailing forces to doctors' pricing power in the market for the services of senior private sector specialists, some top surgeons in Tasmania are earning well over a million dollars a year. Although only a few people are getting this sort of money, the benchmark is important in terms of the expectations of other practitioners throughout the health system.

A senior doctor working under a public sector award has a ceiling of around \$300,000 a year, less than a quarter of the income enjoyed by some private specialists. The public sector clearly cannot afford either the money directly involved in paying these people or, more importantly, the demands that would then flow from other people being paid the award rates. That would eventually involve a massive increase in wage costs which would inevitably flow through to other staff.

To try to deal with this impasse, a system has been set up to allow many specialists the right of private practice as part of their contracts: the private patients scheme. It has its own staff and functions as an administration-within-an-administration, encouraging

patients with private insurance to agree to have their insurers billed for their care. They are given right to choose their doctor and are promised that there will be no out-of-pocket fee. At the federal level, two regulatory principles intersect. The inter-governmental agreements under which the Commonwealth helps to fund state public hospitals requires all patients to have the right to be treated as private and to have the choice of doctor. The agreement says:

G15: In particular, private patients have a choice of doctor and all patients will make an election based on informed financial consent.¹⁰

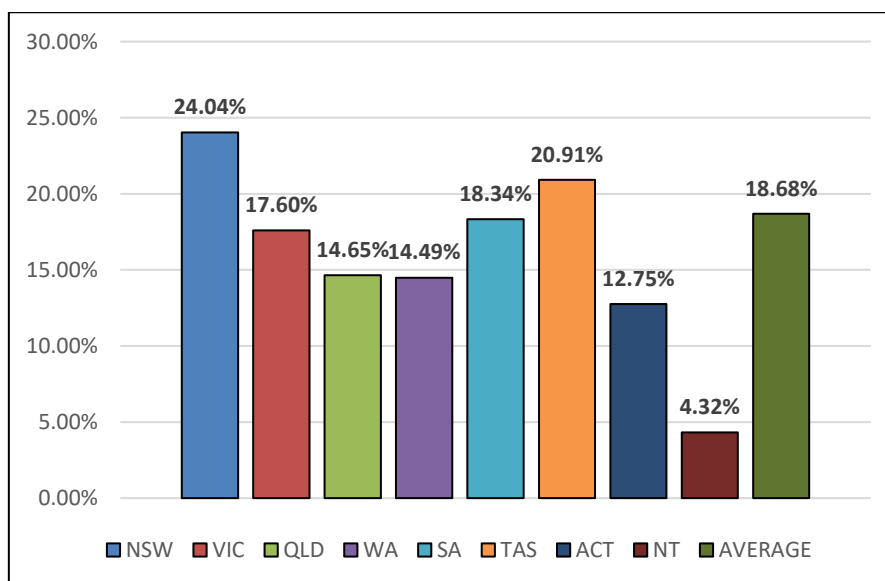
It also says:

A6: ... the Commonwealth will not fund patient services through this Agreement if the same service, or any part of the same service, is funded through any of these benefit programs or any other Commonwealth program.¹¹

Because the Commonwealth provides a rebate to patients of 27% of private health insurance premiums, it refuses to reimburse public hospitals if a patient's private insurance does not cover the entire cost of care. On average, about 95% of the payment from private insurance goes to the doctor and only 5% to the hospital. For public patients, the Commonwealth provides 45% of the total cost of care but because this cannot be claimed in the case of private patients, hospitals make a substantial loss. On average, Tasmanian public hospitals make a loss of around \$1,500 per private patient, compared with treating the same patient publicly. This represents a total annual loss to the hospitals of \$38 million. This means there is less money to treat public patients; and so, in turn, less activity-based Commonwealth funding can be claimed. And so the cycle continues.

The complexity of cases varies little, overall, between public and private patients. This is seen in the length of stay statistics: if private cases were simpler, there would be a considerable difference between the rate of insurance-funded cases and the rate of insurance-funded patient days, as a proportion of all separations. There is not.

Percentage of admitted public hospital patient days funded from private insurance, 2016-17



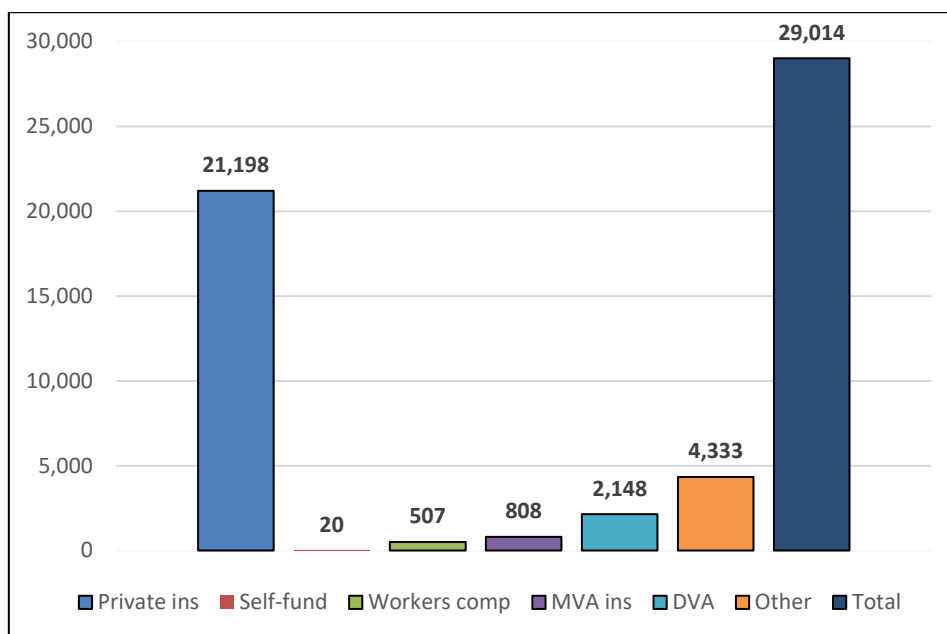
Source: AIHW, *Admitted patient care 2016-17*

10. National Health Reform Agreement 2011, Schedule G, p. 61.

11. *ibid*, Schedule A, p. 13.

Of all patients funded from sources other than the state health budget, private health insurance comprises by far the biggest category.

Numbers of separations funded by sources other than the public hospital budget, Tasmania 2016-17

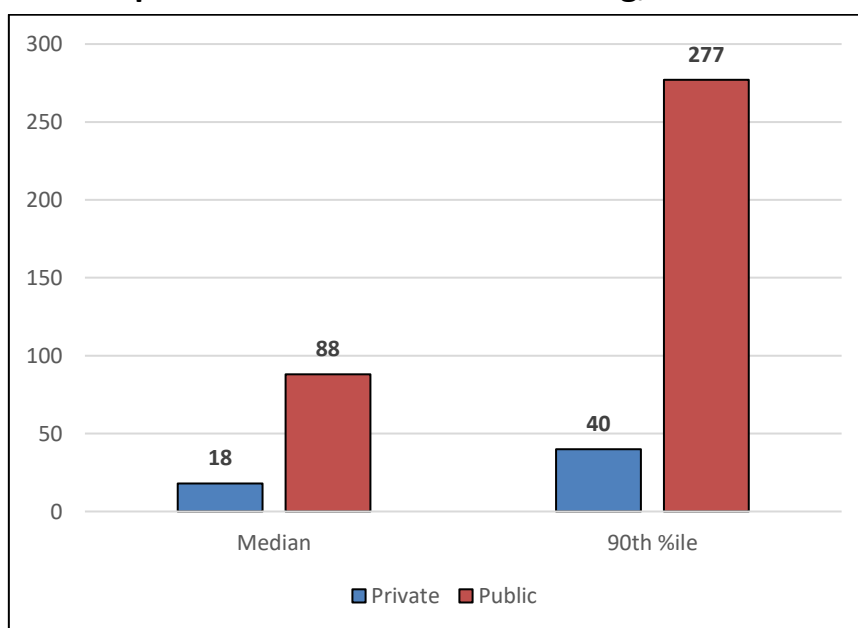


The categories are: private health insurance, self-funded, workers' compensation insurance, motor vehicle accident insurance, and Commonwealth Department of Veterans Affairs. 'Other' includes Other compensation, Department of Defence and correctional facilities.

Source: AIHW, Admitted patient care 2016-17.

But despite statements to the contrary, private patients in public hospitals obtain special treatment. In Tasmania, public elective surgery patients wait much longer for their procedures than those treated privately in the same public hospital.

Days waited by patients admitted from elective surgery waiting lists, by public or private health insurance funding, Tasmania 2016-17



Source: AIHW, Admitted patient care 2016-17.

This difference can at least partly be explained by patients seeing a surgeon in his or her private rooms for the initial consultation. The surgeon can then schedule that patient for a procedure in the public hospital, allowing that person to jump the queue. This also means jumping entirely the long waiting time public patients experience getting their first specialist consultation: people are not placed on the elective surgery waiting list until they have had this first consultation.

The difference cannot be plausibly explained by any major difference in the urgency of cases.

Private practice schemes differ state to state. In Queensland and New South Wales, all private billings are paid to the state Treasury and doctors who are members of the scheme receive a 30% bonus on their salary. Tasmania's is the most generous to doctors and the least generous to hospitals and public patients. It is therefore of particular concern that the federal Health Minister, Greg Hunt, has proposed measures which would further penalise public hospitals.

As part of its 'budget recovery program' the new Liberal government in South Australia has announced moves to greatly increase the proportion of private billings that go to the state. This has met determined opposition from doctor groups.

In Tasmania, similar suggestions have attracted similarly bitter opposition and threats of mass resignations if the proportion of private money going to doctors was to be reduced from its present 95%.

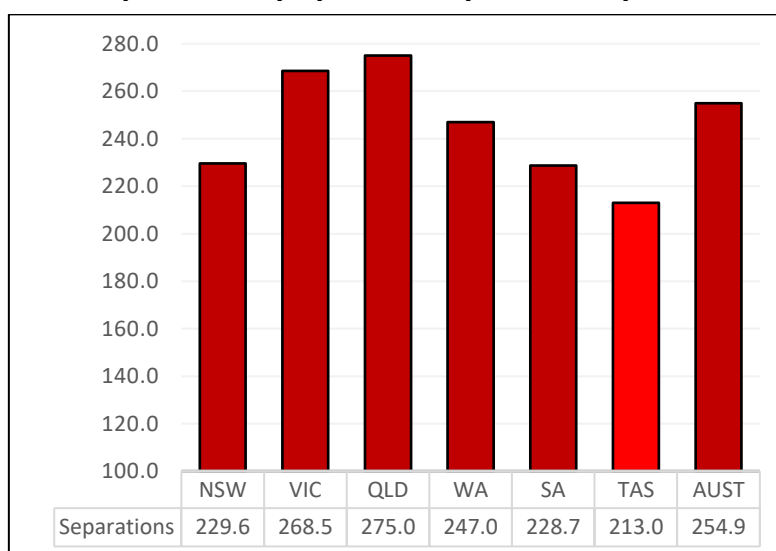
The pressures: admitted patients

ADMITTED patients account for the bulk of work in almost any public hospital. Therefore, the capacity of a hospital, or a state hospital system, to treat those needing the greatest level of care is the key indicator of adequacy.

On almost all measures, the Tasmanian system is the least able to cope with the pressures of the demand being placed upon it. Given the particular needs of this state's population, Tasmanian public hospitals should be delivering the most care of any state or territory system. Instead, they are delivering the least. The result is that impossible demands are being placed on hospital staff and the huge reservoir of unmet need is growing ever larger.

Tasmanian public hospital care is both the most inadequate and the least safe in the country.

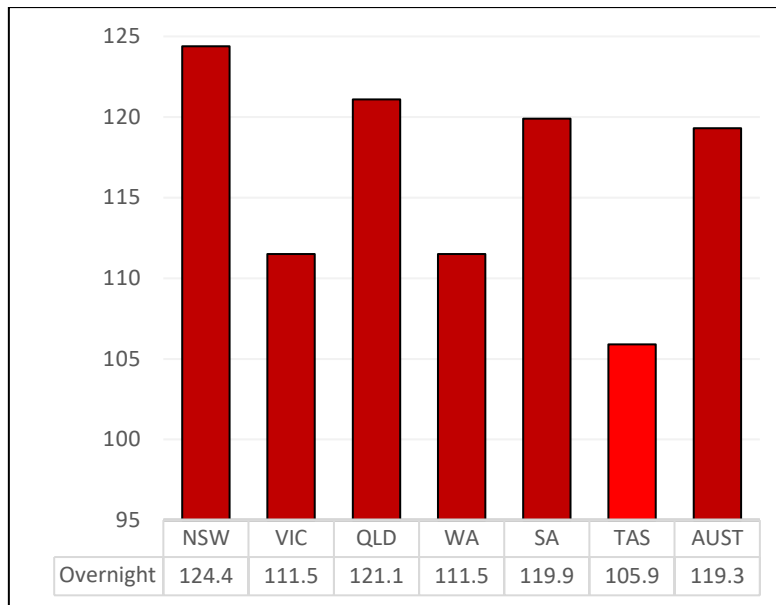
Separations per 1,000 population, public hospitals, 2016-17¹²



In Tasmania, an even greater disparity can be seen in the data for overnight separations. These patients are by definition the most seriously ill and in the need of the most care. This is, another indicator of the inability of the system to cope with the demands being placed upon it.

12. AIHW, Admitted Patient Care 2016-17: Who used these services? A separation is a completed episode of admitted patient care. The two territories have been omitted because of their atypical patient profiles. Rates of separations in the territories are much higher than in the rest of the country: in the NT because of its indigenous population and in the ACT because people in southern NSW being treated in Canberra.

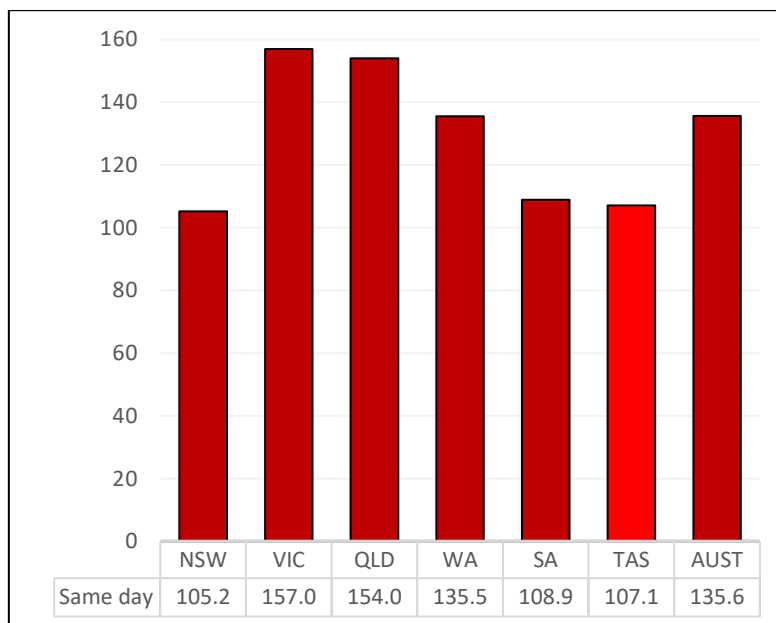
Overnight separations per 1,000 population, public hospitals 2016-17



AIHW, Admitted Patient Care 2016-17

There is somewhat less of a disparity in same-day separations, generally the simplest and cheapest patients to treat. This result is partly due to the state government's use of left-over Commonwealth funding to treat large numbers of long-wait patients needing simple and cheap procedures, mainly colonoscopies and cataract operations. This had the effect of shortening the waiting-list data without making a comparable change to the total amount of work needed to be done.

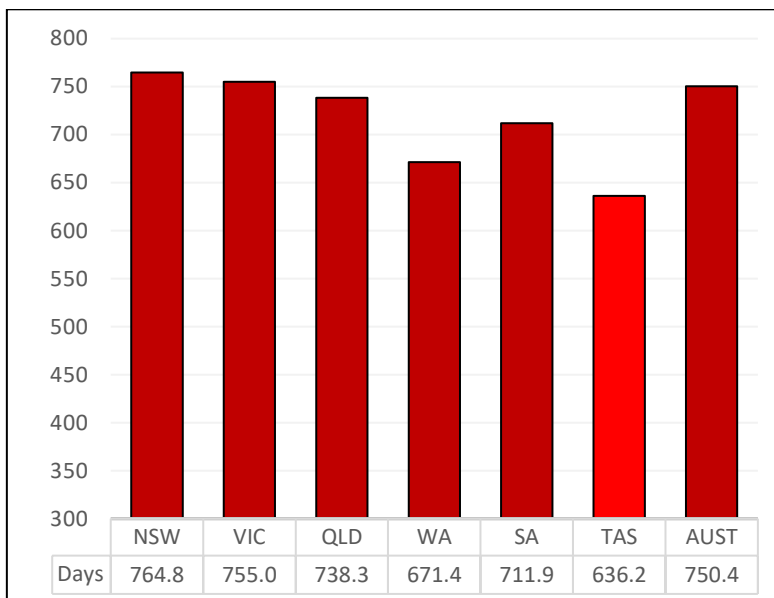
Same-day separations per 1,000 population, public hospitals, 2016-17⁸



AIHW, Admitted Patient Care 2016-17

The broadest measure of admitted patient capacity is the number of patient days – that is, the number of patients multiplied by the number of days they are in hospital. Again, the same pattern emerges: Tasmania delivers less hospital care than any other state, even though the need for that care is the highest in the nation.

Patient days per 1,000 population, public hospitals, 2016-17⁸



AIHW, Admitted Patient Care 2016-17

Average cost weight figures indicate the cost and complexity of the overall patient mix in a state hospital system: a cost weight higher than 1.0 shows that disproportionately more complex – and sicker – people are being treated; a figure lower than 1.0 shows a less complex patient mix. Tasmania’s average cost weight is the highest in the country, at 1.07. One likely reason for this is that the system is treating those whose condition has become serious and can no longer be deferred.

Average cost weights, public hospitals, 2016-17



AIHW, Admitted Patient Care 2016-17

Such difficult rationing decisions are being increasingly forced on staff in hospitals that cannot deal with everyone in need of care.

The increased workload in Tasmania’s public hospitals over the past several years – particularly in the Royal Hobart and Launceston General hospitals – shows how staffing and other resources have failed to keep up with rising demand.

All of these pressures have increased substantially over the last several years. Typically, the growth in demand in Tasmanian hospitals outstrips other jurisdictions but the rate has slowed since the present government took office. Either this is because fewer people need care – which is not a plausible explanation – or because hospitals have run out of room and staff to do more.

As we can see in the following three tables, there has been a much faster increase in same-day separations than in overnight care, most probably a direct result of a lack of beds and staff.

Separations in Tasmanian public hospitals, 2011-12 to 2016-17

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Change
Separations	99,632	106,358	114,033	119,506	122,604	124,412	
% increase		6.75%	7.22%	4.80%	2.59%	1.47%	24.87%

Source: AIHW, myhospitals.com.au, Patient admissions data.

Overnight separations in Tasmanian public hospitals, 2011-12 to 2016-17

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Change
Overnight	47,009	47,877	51,277	52,807	53,528	54,871	
% increase		1.85%	7.10%	2.98%	1.37%	2.51%	16.72%

Source: AIHW, myhospitals.com.au, Patient admissions data.

Same-day separations in Tasmanian public hospitals, 2011-12 to 2016-17

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Change
Same-day	50,462	55,765	60,011	63,507	62,679	62,722	
% increase		10.51%	7.61%	5.83%	-1.30%	0.07%	24.30%

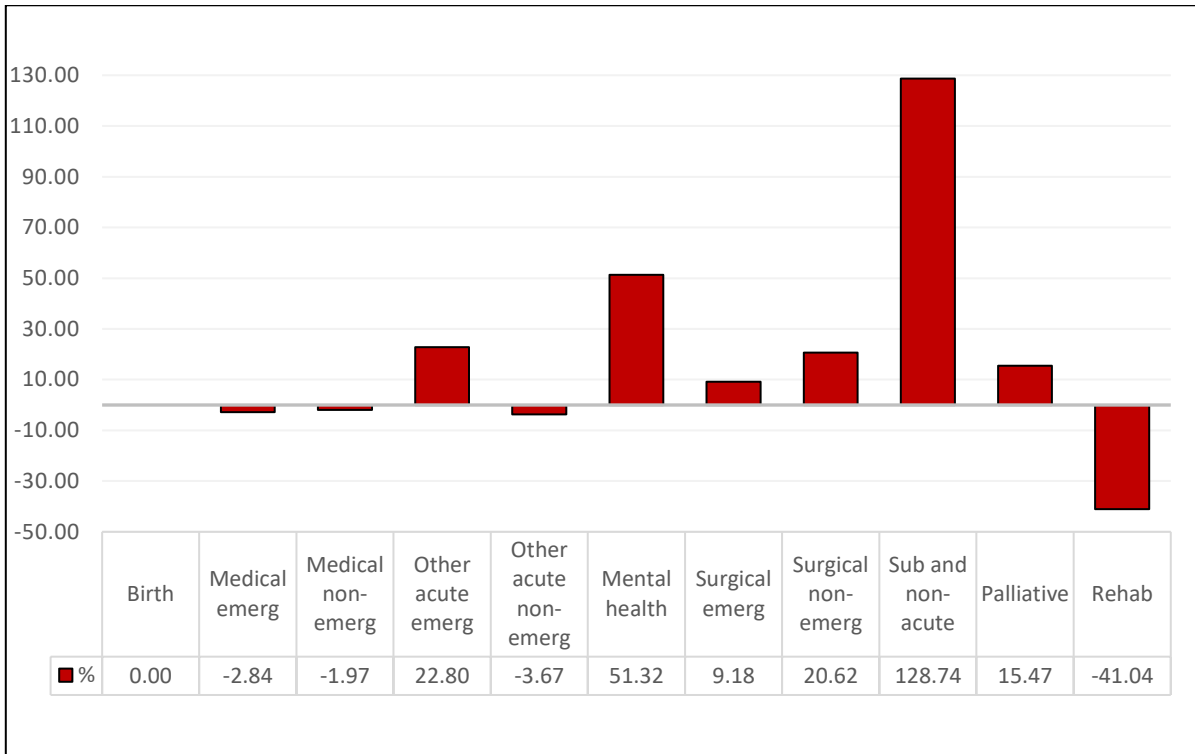
Source: AIHW, myhospitals.com.au, Patient admissions data.

When we look at the data for each of the state’s two main hospitals, the picture becomes clearer. Over the five years to 2016-17, the admissions at the Royal Hobart Hospital increased by 18.09% and at the Launceston General Hospital by 36.88%. The difference between the hospitals shows that the RHH became full before the LGH; but neither hospital can realistically accept a greater workload than it does now without a major and immediate increase in staffing and resources.

Within each hospital, the increases were not evenly spread. As the following charts show, mental health admissions increased by 75.1% at the LGH and at the RHH, at a time when mental health bed numbers were being reduced, admissions rose by 51.32%. RHH sub-acute and non-acute admissions rose by 128.74%.

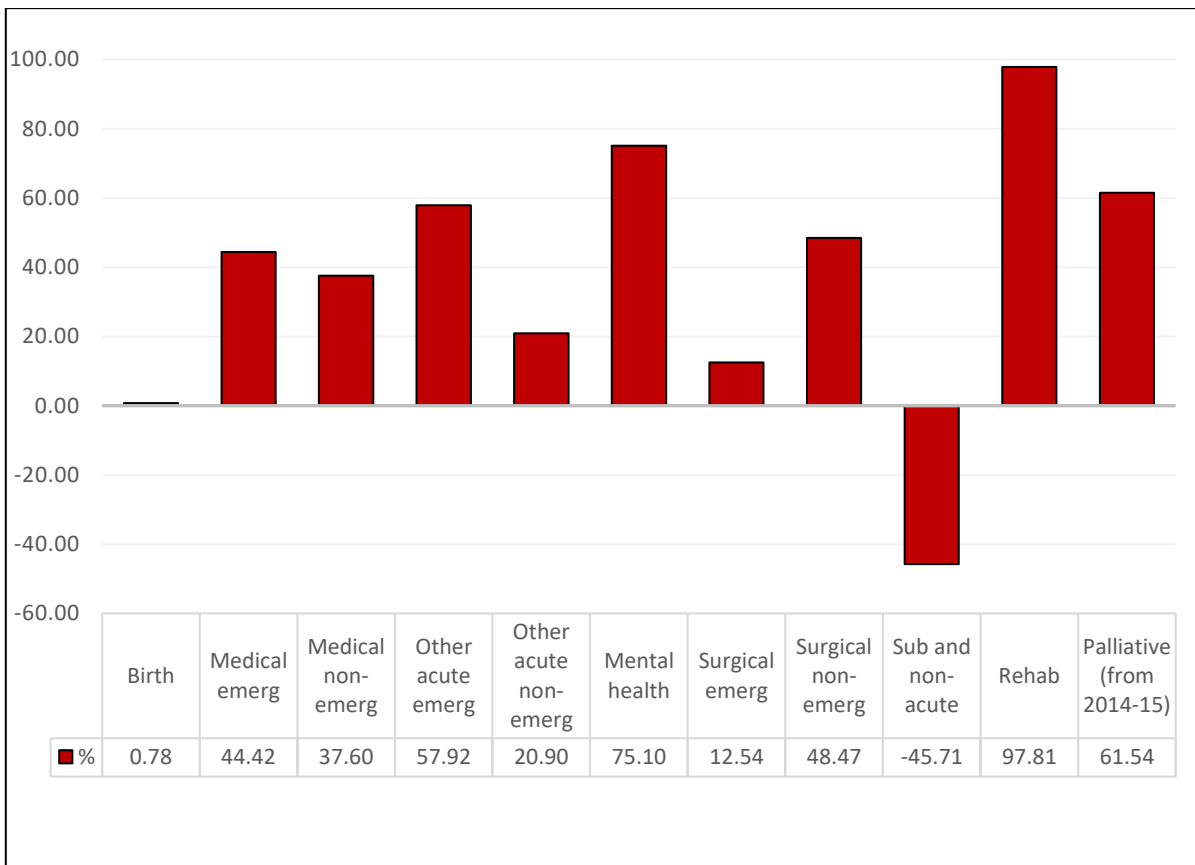
Overall, the LGH had the greatest increase, rising substantially in all categories except one.

Percentage change in admissions, Royal Hobart Hospital, 2011-12 to 2016-17



Source: AIHW, myhospitals.gov.au/

Percentage change in admissions, Launceston General, 2011-12 to 2016-17



Source: AIHW, myhospitals.gov.au

This table shows how the number of staffed and available beds has failed to keep pace with increasing demand. While the caseload increased by 24.87% over the five years, the numbers of beds increased by only 9.76%. Over the period, an extra 281 beds would have had to be provided to keep up with demand. Another way of looking at this is that now, in 2018, the state system would require about an extra 350 fully staffed beds to get back to the capacity levels it had in 2011, before the budget squeezes of both governments began.

Bed numbers versus caseload in Tasmanian public hospitals, 2011-12 to 2016-17

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Cumulative
Separations	99,632	106,358	114,033	119,506	122,604	124,412	
% increase		6.75%	7.22%	4.80%	2.59%	1.47%	24.87%
Beds	1,188	1,188	1,187	1,299	1,314	1,304	
% increase		0.00%	-0.08%	9.44%	1.15%	-0.76%	9.76%
Shortfall (n)		-80	-86	-62	-34	-19	-281

Source: AIHW, Admitted patient care 2016-17; Hospital resources 2016-17.

This increasing shortage of resources has had three main effects: an increasing inability to treat people in need of hospital care, as we have seen; increasing pressures on staff, with serious consequences for staff welfare and the capacity to recruit; and on the safety and quality of care.

An indicator of an overworked staff is the level of accumulated annual leave. For nurses, this stood at 634,323 hours at March 2018, worth \$26,195,200. This had blown out considerably over a 12-month period.¹³ Sick leave for nurses accounts for around 5% of their total pay.¹⁴

The overcrowding of hospitals and the chronic and increasing overwork of staff inevitably has a cost in the safety and quality of care. Put simply, patients are more likely to be hurt or, sometimes, to die in such conditions.

On the three currently available measures which compare states – readmissions, falls and unforeseen complications, the care offered by Tasmania’s public hospitals is the nation’s least safe and of the poorest quality. The rate of unplanned readmissions within 28 days of discharge is a reliable indicator that something has probably gone wrong with their care. This table tells the story: the worst results in each category are highlighted.

Unplanned readmissions within 28 days per 1,000 separations, 2016-17

	NSW	VIC	QLD	WA	SA	TAS	AUST
Tonsillectomy	24.4	19.6	23.5	29.2	24.0	29.9	23.3
Cataract	2.7	2.4	5.7	1.7	3.7	4.3	3.1
Hip replacement	16.1	16.9	27.3	18.4	13.6	39.9	18.6
Hysterectomy	27.9	29.1	45.7	37.5	27.5	46.0	33.1
Knee replacement	20.5	19.4	32.6	20.9	24.3	44.9	23.2
Prostatectomy	24.8	17.0	31.6	23.9	14.0	11.2	22.5
Tonsils & adenoids	35.8	28.1	58.9	62.1	42.7	56.6	39.8

Source: AIHW, Admitted patient care 2016-17, Safety and quality

13. DHHS, RTI 12017-18-068, 4 June 2018.

14. DHHS, RTI2017-18-067, 4 June 2018.

It should be noted that cataract excisions for public patients in Tasmania are significantly farmed out to private ophthalmology practices rather than being performed within public hospitals.

A similar story emerges with data on falls:

Rates of falls resulting in patient harm, 2016-17

	NSW	VIC	QLD	WA	SA	TAS	AUST
Falls per 1,000 separations	6.2	3.8	4.2	5.4	5.9	7.6	4.9

Source: AIHW, Admitted patient care 2016-17, Safety and quality

And with unforeseen complications, which may be due to inadequate care:

Percentage of separations with a condition arising during care, 2016-17

	NSW	VIC	QLD	WA	SA	TAS	AUST
% with condition arising	10.0	12.0	10.1	9.6	11.3	12.3	10.5

Source: AIHW, Admitted patient care 2016-17, Safety and quality

There have been many warnings over many years to governments that without a major injection of money, facilities and staff, that patient safety would suffer. Those warnings have routinely been swept aside. As we have seen throughout this paper, a situation which was bad when the present government was elected has since become much worse.

The pressures: emergency

UNLIKE other areas of a hospital, emergency departments cannot ration their treatment. They have no control over how many people walk through the door. So it is here that the failure of resources to keep up with demand is most clearly seen.

In Tasmania, the bulk of pressure on EDs has occurred in the two main hospitals, and particularly the RHH. As the first table below shows, the overall number of presentations rose by 30.78% from 2010-11 (the year before major budget cuts were introduced) to 2016-17. Most of the increased demand was in more complex and demanding cases: emergency presentations rose by 44.06%, urgent by 29.78% and semi-urgent by 37.17%. In contrast, non-urgent cases stayed away, a strong indication that increased workload is not being driven by GP-type cases.

Emergency department presentations, RHH, 2011-12 to 2016-17

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	TOTAL*
Resuscitation (n)	379	477	404	386	492	439	2,577
Resus change (n)		98	-73	-18	106	-53	60
Resus change (%)		25.86%	-15.30%	-4.46%	27.46%	-10.77%	15.83%
Emergency (n)	4,337	4,801	5,178	5,053	5,815	6,248	31,432
Emerg change (n)		464	377	-125	762	433	1,911
Emerg change (%)		10.70%	7.85%	-2.41%	15.08%	7.45%	44.06%
Urgent (n)	15,504	17,402	17,592	18,661	19,460	20,121	108,740
Urgent change (n)		1,898	190	1,069	799	661	4,617
Urgent change (%)		12.24%	1.09%	6.08%	4.28%	3.40%	29.78%
Semi-urgent (n)	17,744	18,281	20,659	21,489	23,140	24,339	125,652
Semi-urg change (n)		537	2,378	830	1,651	1,199	6,595
Semi-urg change (%)		3.03%	13.01%	4.02%	7.68%	5.18%	37.17%
Non-urgent (n)	6,856	6,667	7,186	7,685	7,323	7,470	43,187
Non-urg change (n)		-189	519	499	-362	147	614
Non-urg change (%)		-2.76%	7.78%	6.94%	-4.71%	2.01%	8.96%
TOTAL (n)	44,820	47,628	51,019	53,274	56,230	58,617	311,588
TOTAL CHANGE (n)		2,808	3,391	2,255	2,956	2,387	13,797
TOTAL CHANGE (%)		6.27%	7.12%	4.42%	5.55%	4.25%	30.78%

*Cumulative totals 2010-11 to 2016-17.

Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

At the LGH there was a similar, though less pronounced, trend. A major difference was the large increases at both ends of the triage hierarchy: resuscitation and emergency, and non-urgent.

Emergency department presentations, LGH, 2011-12 to 2016-17

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	TOTAL*
Resuscitation (n)	170	173	154	165	216	272	1,150
Resus change (n)		3	-19	11	51	56	102
Resus change (%)		1.76%	-10.98%	7.14%	30.91%	25.93%	60.00%
Emergency (n)	3,288	3,351	3,069	3,485	3,970	4,412	21,575
Emerg change (n)		63	-282	416	485	442	1,124
Emerg change (%)		1.92%	-8.42%	13.55%	13.92%	11.13%	34.18%
Urgent (n)	14,993	14,896	15,235	14,379	14,992	16,051	90,546
Urgent change (n)		-97	339	-856	613	1,059	1,058
Urgent change (%)		-0.65%	2.28%	-5.62%	4.26%	7.06%	7.06%
Semi-urgent (n)	18,959	20,750	20,858	20,184	19,105	17,565	117,421
Semi-urg change (n)		1,791	108	-674	-1,079	-1,540	-1,394
Semi-urg change (%)		9.45%	0.52%	-3.23%	-5.35%	-8.06%	-7.35%
Non-urgent (n)	1,660	1,966	2,766	3,192	2,973	3,294	15,851
Non-urg change (n)		306	800	426	-219	321	1,634
Non-urg change (%)		18.43%	40.69%	15.40%	-6.86%	10.80%	98.43%
TOTAL (n)	39,070	42,896	42,228	40,302	41,326	41,611	247,434
TOTAL CHANGE (n)		3,826	-668	-1,926	1,024	285	2,541
TOTAL CHANGE (%)		9.79%	-1.56%	-4.56%	2.54%	0.69%	6.50%

*Cumulative totals 2010-11 to 2016-17.

Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

In the two north-western hospitals, workload tended to remain stable, showing none of the major increase in demand seen in the two larger institutions.

Emergency department presentations NWRH, 2011-12 to 2016-17

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	TOTAL*
Resuscitation (n)	94	91	105	129	186	142	747
Resus change (n)		-3	14	24	57	-44	48
Resus change (%)		-3.19%	15.38%	22.86%	44.19%	-23.66%	51.06%
Emergency (n)	1,553	1,721	1,713	1,736	1,960	2,260	10,943
Emerg change (n)		168	-8	23	224	300	707
Emerg change (%)		10.82%	-0.46%	1.34%	12.90%	15.31%	45.52%
Urgent (n)	7,800	8,150	7,963	8,101	8,431	8,508	48,953
Urgent change (n)		350	-187	138	330	77	708
Urgent change (%)		4.49%	-2.29%	1.73%	4.07%	0.91%	9.08%
Semi-urgent (n)	11,809	11,302	10,826	10,899	10,800	10,693	66,329
Semi-urg change (n)		-507	-476	73	-99	-107	-1,116
Semi-urg change (%)		-4.29%	-4.21%	0.67%	-0.91%	-0.99%	-9.45%
Non-urgent (n)	1,411	1,007	821	1,265	1,360	1,277	7,141
Non-urg change (n)		-404	-186	444	95	-83	-134
Non-urg change (%)		-28.63%	-18.47%	54.08%	7.51%	-6.10%	-9.50%
TOTAL (n)	22,667	22,279	20,771	22,388	23,250	23,106	134,461
TOTAL CHANGE (n)		-388	-1,508	1,617	861	-144	439
TOTAL CHANGE (%)		-1.71%	-6.77%	7.79%	3.85%	-0.62%	1.94%

*Cumulative totals 2010-11 to 2016-17.

Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

Emergency department presentations, MCH, 2011-12 to 2016-17

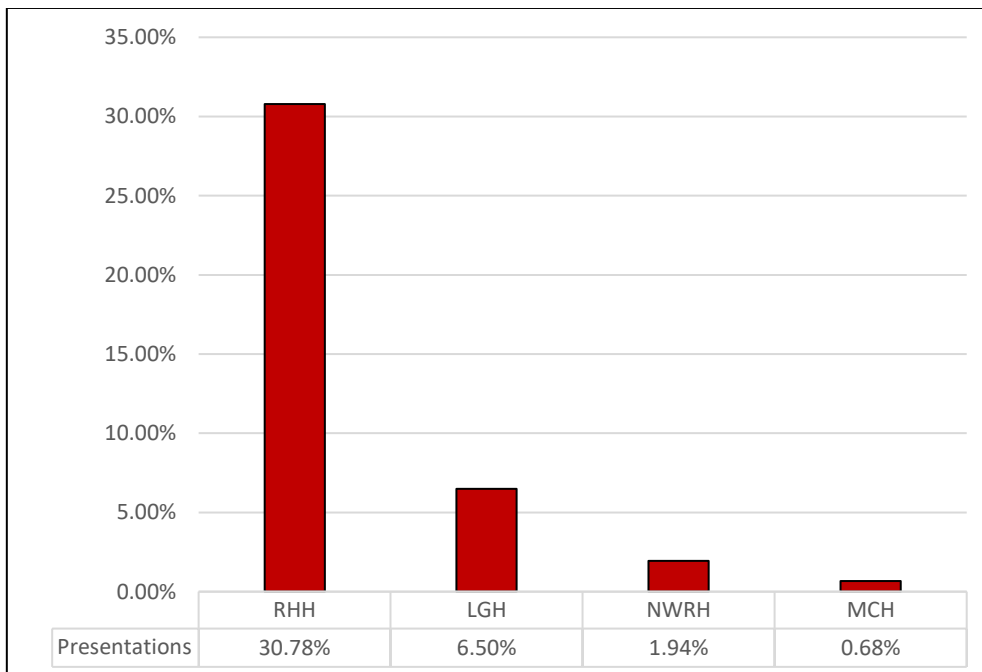
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	TOTAL*
Resuscitation (n)	44	73	72	74	84	77	424
Resus change (n)		29	-1	2	10	-7	33
Resus change (%)		65.91%	-1.37%	2.78%	13.51%	-8.33%	75.00%
Emergency (n)	1,267	1,590	2,213	1,981	2,400	2,606	12,057
Emerg change (n)		323	623	-232	419	206	1,339
Emerg change (%)		25.49%	39.18%	-10.48%	21.15%	8.58%	105.68%
Urgent (n)	6,781	7,796	8,254	8,618	9,085	9,000	49,534
Urgent change (n)		1,015	458	364	467	-85	2,219
Urgent change (%)		14.97%	5.87%	4.41%	5.42%	-0.94%	32.72%
Semi-urgent (n)	13,048	13,855	12,693	11,964	11,326	10,820	73,706
Semi-urg change (n)		807	-1,162	-729	-638	-506	-2,228
Semi-urg change (%)		6.18%	-8.39%	-5.74%	-5.33%	-4.47%	-17.08%
Non-urgent (n)	2,422	1,959	1,822	1,442	1,422	1,291	10,358
Non-urg change (n)		-463	-137	-380	-20	-131	-1,131
Non-urg change (%)		-19.12%	-6.99%	-20.86%	-1.39%	-9.21%	-46.70%
TOTAL (n)	23,562	27,448	24,972	23,484	24,575	23,402	147,444
TOTAL CHANGE (n)		3,886	-2,476	-1,488	1,091	-1,173	-160
TOTAL CHANGE (%)		16.49%	-9.02%	-5.96%	4.65%	-4.77%	-0.68%

*Cumulative totals 2010-11 to 2016-17.

Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

The following chart clearly shows how emergency department demand has been concentrated at the RHH.

Percentage increase in emergency presentations, 2010-11 to 2016-17

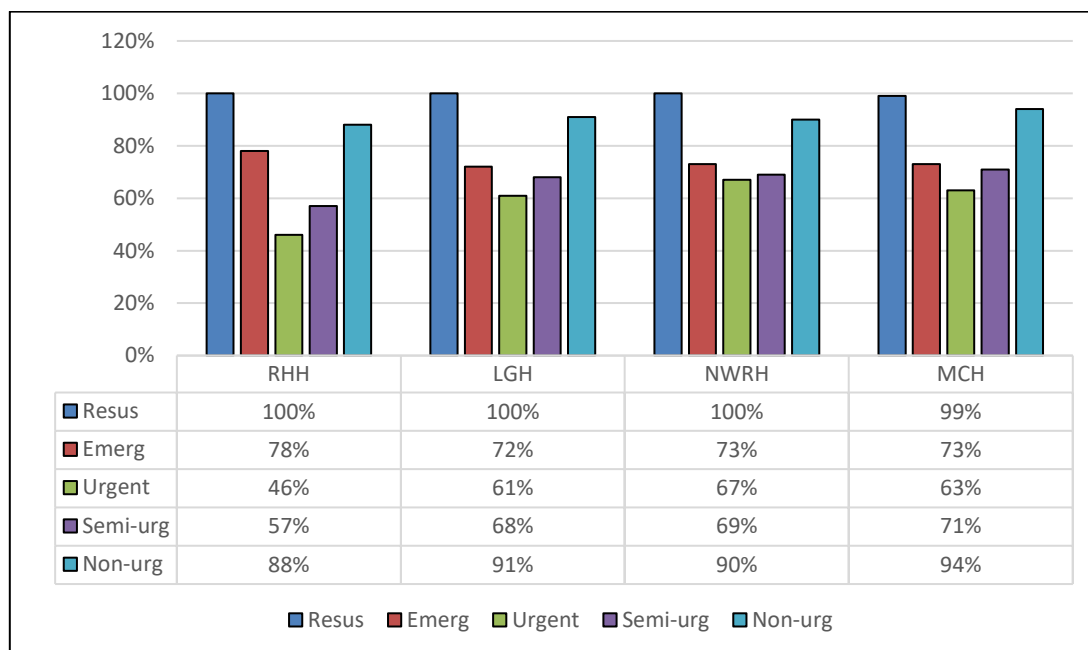


Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

Despite the increased workload, emergency department staff have generally been able to deal surprisingly well with patients who do not require admission. Nevertheless, in all four hospitals, inadequate resources means not everyone can be seen on time.

Resuscitation patients cannot be delayed and are dealt with immediately; non-urgent cases require relatively little care. The middle-urgency categories tend to suffer.

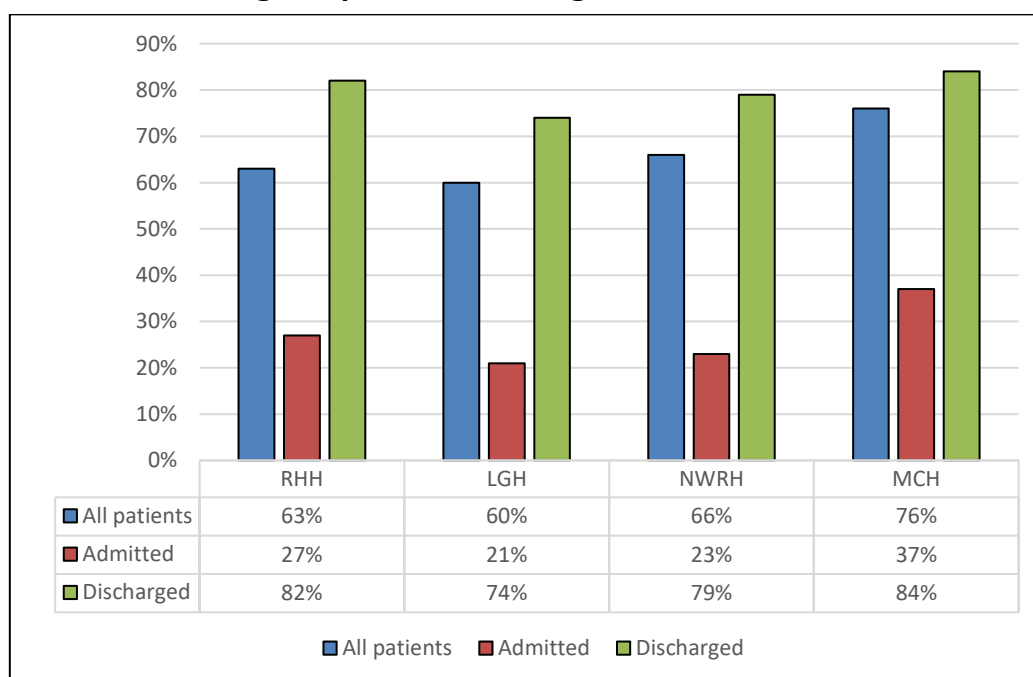
Percentage of patients seen on time, 2016-17



Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

In all hospitals there is a target that patients should be able to leave the ED – either treated and discharged or admitted to a specialist ward – within four hours. Tasmania’s public hospitals usually achieve this goal only with patients who do not require admission. People cannot be admitted to a bed if there is no bed for them.

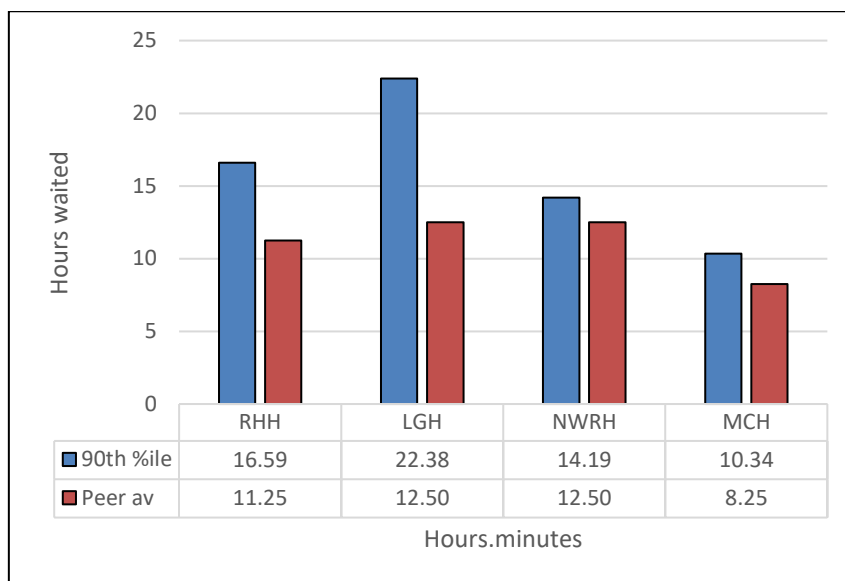
Percentage of patients leaving ED in 4 hours, 2016-17



Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

Although bed block – where patients have to remain in the ED because there is no room on a ward – is a serious problem in all states, it is worse in Tasmania than elsewhere. Again, it is the two major hospitals which bear the brunt.

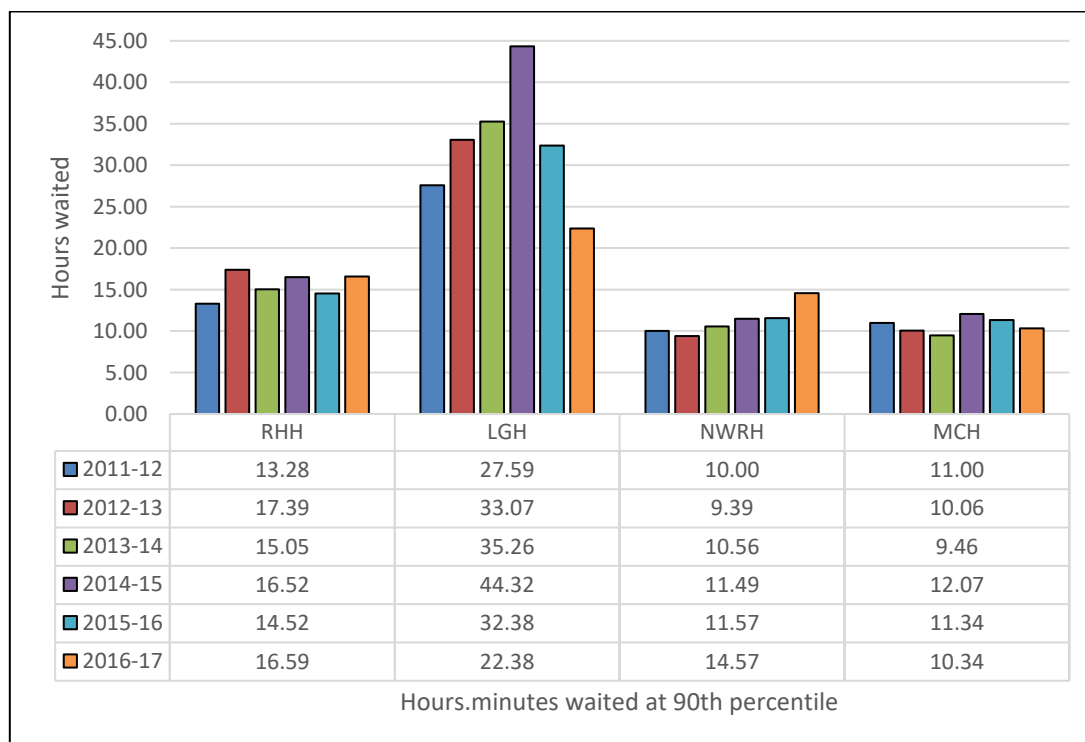
Bed block: time waited in ED for patients needing admission and national peer group averages, 90th percentile, 2016-17



Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

The standard measure of bed block is the time waited in ED by patients needing admission at the 90th percentile – that is, when 90% have been admitted and 10% are still waiting.

Bed block: time waited in ED for patients needing admission and national peer group averages, 90th percentile, 2011-12 to 2016-17



Source: AIHW, myhospitals.gov.au, Time spent in emergency departments.

In 2016-17 bed block at the RHH was the third-worst of all 30 major hospitals in its national peer group; the LGH was worst among the 29 major regional hospitals; time waited at the NWRH was 21st longest of 29 large regional hospitals; and at the MCH was 17th longest of 21 medium regional hospitals.

Overall, the LGH had the worst bed block of any of the 287 public hospitals in Australia with emergency departments. And only eight had a worse result than the RHH. Staff at both hospitals attest that the situation has continued to deteriorate in the past year.

Bed block has serious health consequences. Research in Australia and elsewhere has shown that patients affected by bed block have a 30% increased risk of death.¹⁵ Studies at a hospital in Canberra¹⁶ and three hospitals in Perth¹⁷ yielded an estimate that bed block caused 8 deaths a year for every 100,000 population: the researchers described this estimate as conservative. Applied directly to Tasmania, this would mean just over 40 avoidable deaths a year. But as bed block in Tasmania is twice (RHH) or three times (LGH) as bad as in those hospitals in Canberra and Perth; and as the risk of death increased with length of stay in an ED,¹⁸ a more realistic conclusion would be that in excess of 80 people die avoidably in Tasmanian hospitals because of emergency department bed block. Again, this is likely to be a conservative figure: Tasmanians seeking hospital care tend to be sicker (and therefore with higher baseline mortality risk) than the Australian population as a whole.

Some of these cases come to the attention of the coroner. Most do not.

As well as death, many other patient outcomes suffer. These have been shown to include heart attacks and extradural haematoma missed by staff, failure to adhere to cardiac treatment protocols, delays to treating heart-attack patients, delays in administering antibiotics for pneumonia, worse pain management and higher rates of complications following heart attacks.¹⁹

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17. Fatovich DM, Nagree Y, Spirivulis P. Access block causes emergency department overcrowding and ambulance diversion in Perth, Western Australia. *Emerg Med J* 2005; 351-354.

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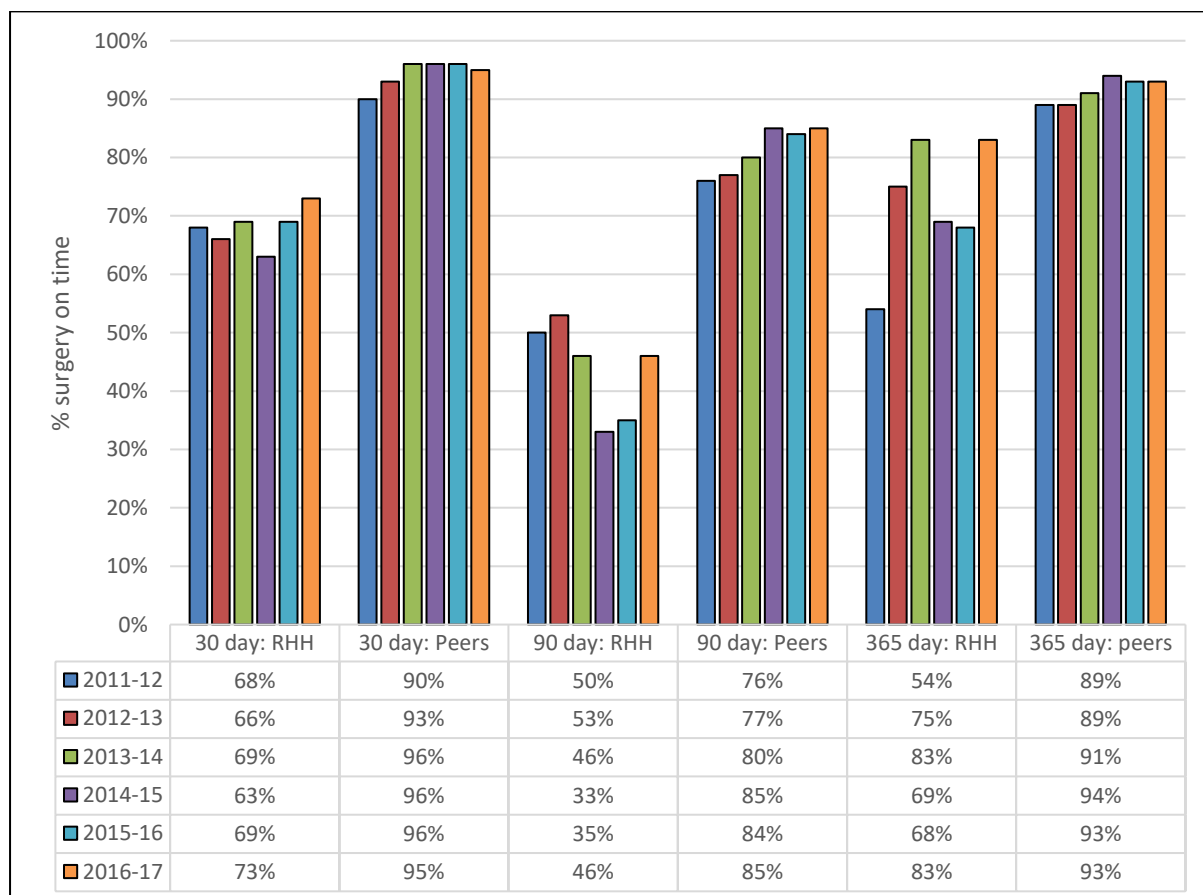
The pressures: elective surgery

ELECTIVE surgery is defined as any procedure which can be delayed by at least 24 hours. It does not mean that the surgery is optional: elective procedures include correction to life-threatening cardiac conditions, hip replacements, colonoscopies to detect bowel cancer and cataract operations. None of these can be described as optional but if all cannot be done at once, some can wait. But there are limits to the time patients should be made to wait: most are enduring significant discomfort, pain or disability. Many, if delayed for too long, will see their condition worsening, sometimes progressing from elective to emergency.

For these reasons, three broad urgency levels have been developed. The most serious need their procedures within 30 days; the next urgent, within 90 days; and the least urgent within a year. Ideally, no patient should have to wait for longer than this.

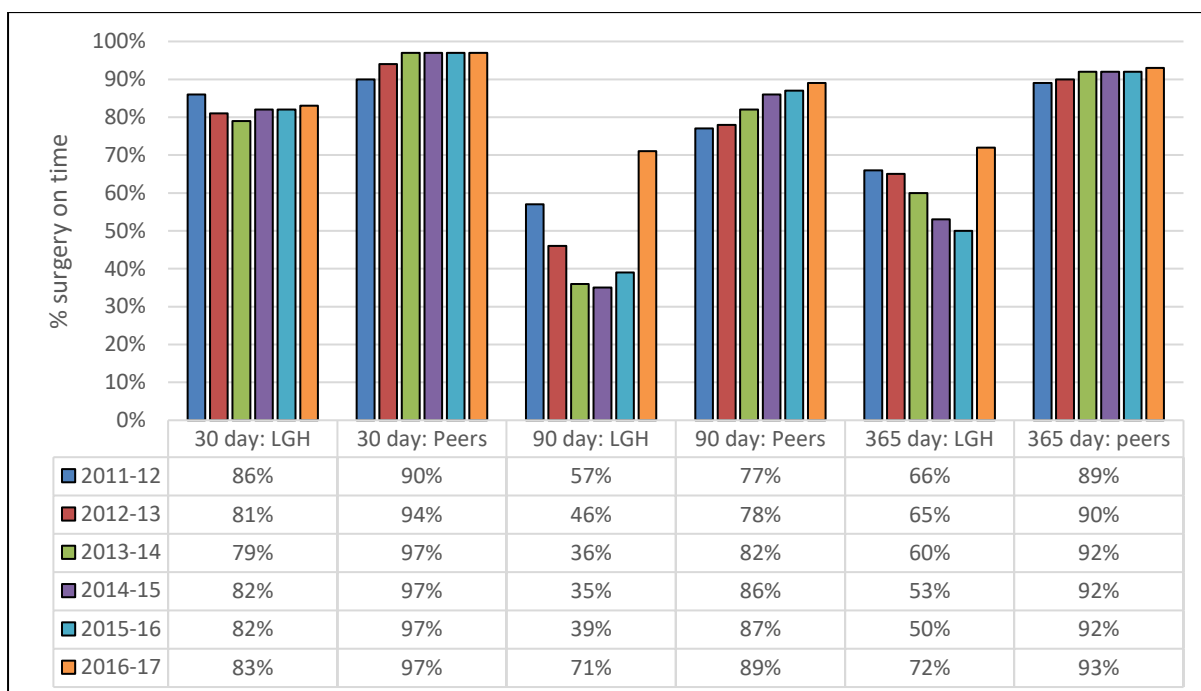
In Tasmanian public hospitals, many do. Although the national averages for each of the hospital peer groups vary, all of this state's four main hospitals fall below either the clinically recommended guidelines and the performance of similar hospitals around the country. The following charts show how the gap between each of those four hospitals and comparable institutions elsewhere over a five-year period.

Percentages of elective surgery delivered on time: Royal Hobart Hospital and major hospital national peer group, 2011-12 to 2016-17



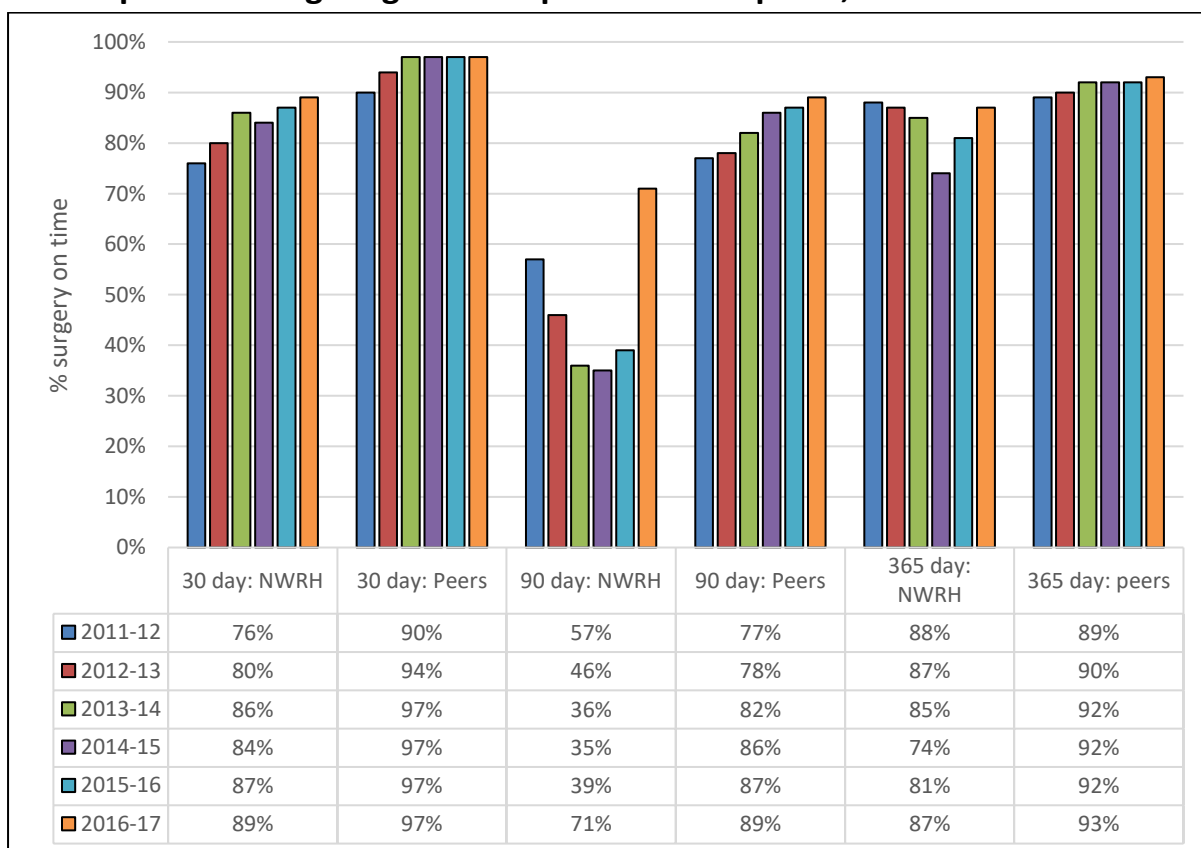
Source: AIHW, myhospitals.gov.au, Elective surgery data.

Percentages of elective surgery delivered on time: Launceston General Hospital and large regional hospital national peer group, 2011-12 to 2016-17



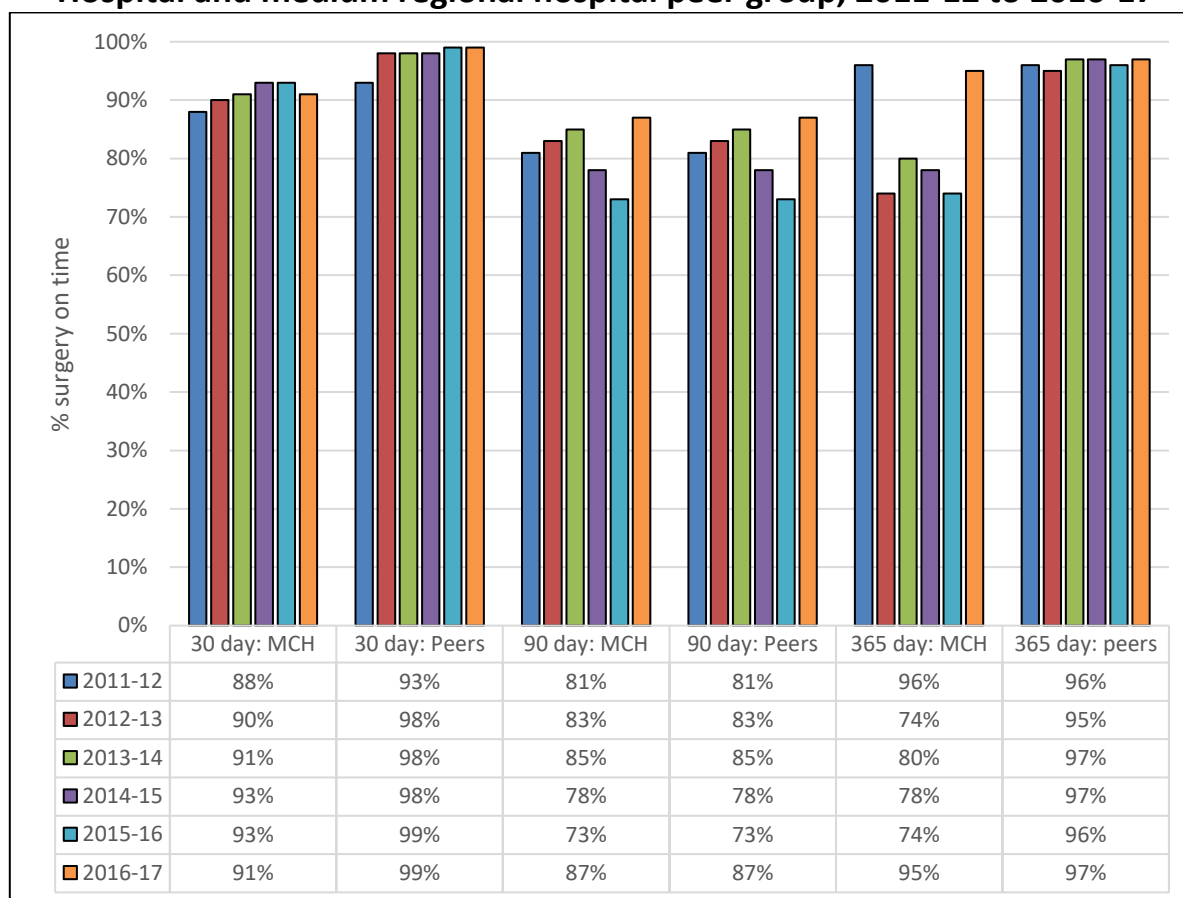
Source: AIHW, myhospitals.gov.au, Elective surgery data.

Percentages of elective surgery delivered on time: North-West Regional Hospital and large regional hospital national peers, 2011-12 to 2016-17



Source: AIHW, myhospitals.gov.au, Elective surgery data.

Percentages of elective surgery delivered on time: Mersey Community Hospital and medium regional hospital peer group, 2011-12 to 2016-17



Source: AIHW, myhospitals.gov.au, Elective surgery data.

In terms of the time patients have to wait for their operation after being placed on the elective surgery waiting list, Tasmania once again has the worst results in the nation. The extent of this is partly revealed in the following table. The time waited at the 90th percentile level – where 90% of patients have been admitted and 10% are still waiting – is much longer than the nation as a whole, though on this measure NSW is even worse. But Tasmanian patients are almost four times as likely to have to wait for longer than a year for their surgery than the national average.

Time waited by patients admitted from the elective surgery waiting list, Tasmania, 2016-17

Waited	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST
90 th %ile ^(a)	327	162	211	185	237	313	279	202	258
Over 1 year ^(b)	1.6	2.0	0.4	1.5	1.8	6.6	3.8	4.2	1.7

(a) Days waited between being put on the waiting list before surgery takes place.

(b) Percentage of all elective surgery patients who have to wait for longer than 365 days for their surgery after being placed on the waiting list.

AIHW, Elective surgery waiting times, 2016-17.

But this tells only half of the story of elective surgery waiting times. The other half is the time people have to wait, after a referral by their GP, for an initial consultation with a

surgeon. Only then will their names be put on the official elective surgery waiting list. That is why clinic waiting times are known as ‘the waiting list to get on the waiting list’. This can extend by many months or even years the time people needing surgery have to wait for their operation. These times are longest at the state’s main hospital: the figures in the tables below show the time waited by patients at the three-quarter mark in each urgency category. This means 25% of patients have to wait even longer than this. Data on the longest waiting times have not been made available.

According to a number of GPs, some patients – particularly in the non-urgent category – may never be seen. They can expect to be bumped continually further down the list as more urgent cases present. So there is a third group, of people whose GPs do not bother to refer them to a public hospital specialist because they know there is no point.

At the RHH, the 75th percentile waiting time for even the most urgent categories in paediatric ear, nose and throat and neurosurgery – can be almost a year, with 25% waiting even longer. For non-urgent cases of adult with ear, nose and throat problems the figure is five years and three months; for children in this category it is almost three years. In neurosurgery, semi-urgent cases also have to wait for almost three years to get on the official waiting list with, again, 25% waiting longer. For non-urgent neurosurgery patients, the figure is five years and four months.

Time waited (days) for initial consultation by patients at 75th percentile, RHH surgical clinics, at 26 June 2018

	URGENT	SEMI-URGENT	NON-URGENT
Colorectal	53	228	781
Colposcopy	31	66	81
Ear, Nose & Throat	89	1,124	1,890
ENT Paediatric	356	883	1,063
General Surgical	27	67	304
Neurosurgery	301	1,049	1,917
Ophthalmology	90	124	391
Oral & Maxillofacial	24	54	56
Orthopaedic	11	684	413
Paediatrics Surgery	-	116	72
Plastic	17	53	236
Urology	46	145	173
Vascular	28	60	60
Wound	12	103	67

Source: DHHS.

Time waited (days) for initial consultation by patients at 75th percentile, LGH surgical clinics, at 26 June 2018

	URGENT	SEMI-URGENT	NON-URGENT
Colorectal	63	480	996
Ear Nose & Throat	33	257	663
Orthopaedic	41	641	523
Plastic	23	150	528
Surgical	36	779	812
Urology	53	305	747
Vascular	16	348	753

Source: DHHS.

**Time waited (days) for initial consultation by patients at 75th percentile,
NWRH surgical clinics, at 26 June 2018**

	URGENT	SEMI-URGENT	NON-URGENT
Orthopaedic Clinic	15	100	111
Surgical Clinic	19	53	96

Source: DHHS.

**Time waited (days) for initial consultation by patients at 75th percentile,
MCH surgical clinics, at 26 June 2018**

	URGENT	SEMI-URGENT	NON-URGENT
Orthopaedic Clinic	13	118	276
Surgical Clinic	41	91	147
Urology Clinic	65	222	585
Vascular Clinic	28	71	79

Source: DHHS.