SUBMISSION TO THE SENATE SELECT COMMITTEE ON HEALTH

HOBART 3 NOVEMBER 2014

Martyn Goddard

Main points

- Proposed Medicare co-payments will add substantially to the numbers of people avoiding needed GP-level care.
- This avoided care is likely to add more to state public hospital costs than it saves for the Commonwealth through increased co-payments.
- When compared with tax income, Commonwealth health expenditure has risen modestly over a decade and, when the 'mining boom' tax cuts are discounted, has remained steady. State costs, however, have increased sharply.
- Funding a Medical Research Future Fund as proposed by the government is likely to worsen health outcomes for Australians.
- National and state government policy decisions to cut health budgets interact to further erode the capacity to deliver adequate health and hospital services.
- Tasmania has the nation's oldest, sickest and poorest population but spends less *per capita* on health than any other jurisdiction.
- Extra GST money is received because of the state's health needs ($169 million this fiscal year) but is not being spent on health.
- The Australian government's cuts to state budgets are likely to result in lower health spending in Tasmania.
- The Commonwealth cuts also provide political cover for cuts that the state government wants to make.

Primary care co-payments

The committee already has before it a large body of evidence of the impact of existing and planned co-payments on out-of-pocket expenses and on the likelihood of patients therefore avoiding needed health care. For instance, researchers at the University of Sydney used the BEACH primary care data to conclude that the proposed co-payments would add:

- $184 more a year for a family of four with two children under 16;
- $244 more for a self-funded retired couple without concession cards; and
- $199 more for an aged-pensioner couple with concession cards.[1]

These figures are likely to be an under-estimate. When the extra provider charges, as a result in changes to Medicare remuneration, are factored in, the increased cost to patients will be substantially higher. The planned co-payments would add to the already heavy burden of existing co-payments for PBS prescriptions and charges by medical practitioners.

The committee has estimates from the Australian Bureau of Statistics and others of the extent to which patients are avoiding health care because of the cost of existing co-payments. These figures showed that in 2011-12, 19% of people aged 15 and over reported skipping at least one consultation due to cost, 4.9% missed at least one test or scan, and 9.2% did not fill at least one prescription.[2] It has long been realised that co-payments, as well as decreasing clinically unnecessary demand, also decrease necessary demand, with the probability that some patients' conditions will become worse and that they will need more expensive care later on. But there has been little firm evidence of the added costs of hospital care which results from co-payments at GP level. Now there is.

In 2003 the US state of Oregon transformed its low-income Medicaid program into a two-tiered system. For new patients, primary care co-payments were increased; for existing patients, they were left as they were. This provided a natural experiment which, when it was analysed, showed that for every dollar gained through co-payments and avoided care, a similar amount was spent in increased subsequent hospital costs. The study did not attempt to evaluate the impact on patients or to calculate the level of increased morbidity and mortality among those avoiding necessary primary care.[3]

But a study of some 150,000 people affected by the introduction of pharmaceutical co-payments in Quebec revealed something of the extent of those personal clinical costs. After the co-payments were introduced, use of essential drugs fell by 9.12% in elderly patients and by 14.42% in welfare recipients. Adverse clinical events doubled, rising from 5.8 to 12.6 per 10,000 person-months for the elderly and from 14.7 to 27.6 in welfare recipients. Emergency department visits related to reductions in essential drug use increased by 43% for the elderly and by 78% for people on welfare.[4]

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1 Clare Bayram, Christopher Harrison et al, *Estimated impact of proposed GP, pathology and imaging co-payments for Medicare services, and the increased PBS threshold,* Family Medicine Research Centre, Sydney School of Public Health, University of Sydney, July 2014.

2 Analysis by the Australian Institute of Health & Welfare of the ABS Patient Experience Survey 2011-12. *OECD health-care quality indicators for Australia 2011-12,* AIHW, 2014.

3 Neal T Wallace, John McConnell, et al, How effective are co-payments in reducing expenditures for low-income Medicaid beneficiaries? Experience from the Oregon health plan, *Health Services Research,* April 2008, pp 515-530.

4 Robyn Tamblyn, Rejean Laprise et al, Adverse events associated with prescription cost-sharing among poor and elderly persons, *Journal of the American Medical Association,* vol 285 no 4, 24 January 2001.

Perhaps the largest-scale study of the effect of GP-level co-payments on hospital costs was conducted when America's Medicare (for people over 65) introduced a $7 co-payment for doctor visits in some states but not in others. This provided a huge natural experiment which was analysed in a rigorous and well-designed study. The conclusion was that for every dollar gained to the system through primary-care co-payments, hospital costs rose by $3.35.[5]

Some Australian evidence points in the same direction. In the Northern Territory, there was some doubt about the cost-effectiveness of delivering primary care to diabetes patients in very remote communities, so a study was conducted to compare the costs of primary diabetes services with the costs of hospital care if primary attention was not available or withdrawn. For every dollar spent on primary care, hospital costs fell by $3.94 for remote patients and $11.75 for patients in closer-settled areas.[6]

This is relevant to the co-payment question because it indicates the importance of primary medical services in keeping people out of hospital. Barriers which result in lower utilisation of GP-type services are highly likely to result in substantial levels of avoidable hospital care and a rise in overall costs which may be several times the amount gained in co-payments.

Because these studies look at the effects on the elderly, welfare recipients and the chronically ill, an objection to my conclusions might be that the effect on the overall population could be very different. But the majority of consultations at GP level are for concessional patients. For instance, 87.8% of PBS prescriptions in 2012-13 were for concessional patients – largely, the elderly, welfare recipients and people with chronic illness.[7]

In the Australian federal system, the benefits of co-payments under Medicare and the PBS accrue to the Commonwealth but the costs of increased public hospital services accrue to the states. It may therefore be thought that there is little self-interest for federal governments to reverse the trend toward ever-increasing out-of-pocket expenses. But the Commonwealth is responsible for funding around 43% of state public hospital costs: it may therefore be that the overall effect of co-payments is a cost, not a saving, to the Commonwealth budget.

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5 Amal N Trivedi, Husein Moloo, Vincent Mor, Increased ambulatory care copayments and hospitalizations among the elderly, *New England Journal of Medicine,* no. 362, pp 320-328, 28 January 2010.

6 Susan L Thomas, Yuejen Zhao et al, The cost-effectiveness of primary care for indigenous Australians with diabetes living in remote Northern Territory communities, *Medical Journal of Australia,* vol 200 no 1, 16 June 2014, pp 1-6.

7 *PBS Statistics*, year ending June 2013, Department of Health, Canberra [Table 1(b)].

Sustainability

The Prime Minister, the Treasurer and the Health Minister have all used the same word about the government's bill for health care: unsustainable. Cuts must be made because health costs are rising out of control and no sensible administration can go on paying them. The answer in the budget has been to move still more of those costs from the Commonwealth's balance sheet onto those of the states and patients.

But to understand what is going on, we need to go back much further than the May budget. We need to look at how the costs of health, when measured against the capacity of each level of government to pay, have crippled state budgets and state public hospitals while leaving federal coffers largely untouched.

Figures compiled by the Australian Institute of Health and Welfare[8] showing key trends over eleven years show that as a proportion of its tax revenue – the most relevant measure of affordability – the Australian government's health spending has gone from 22.3% in 2001-02 to 26.2% in 2011-12. That cannot fairly be described as unsustainable:

Table 1: Comparison of Commonwealth health funding with tax revenue (constant prices) 2001-02 to 2011-12

Year	*Commonwealth health spending ($m)*	*Growth year on year (%)*	*Commonwealth tax revenue ($m)*	*Growth year on year (%)*	*Ratio (%)*
2001-02	27 549	-	123 738	-	22.3
2002-03	29 780	8.0	139 000	12.3	21.4
2003-04	31 782	6.7	150 620	8.4	21.1
2004-05	35 201	10.7	166 427	10.5	21.2
2005-06	36 743	4.4	178 192	7.1	20.6
2006-07	39 496	7.5	192 583	8.1	20.5
2007-08	44 391	12.4	209 038	8.5	21.2
2008-09	49 588	11.7	198 539	-5.0	25.0
2009-10	52 437	5.7	183 055	-7.8	28.6
2010-11	55 143	5.2	200 881	9.7	27.5
2011-12	58 983	7.0	225 173	12.1	26.2
Over period		**114**		**82**	

Source: AIHW.

But a further look at the available data shows this modest budget hit has been self-inflicted. These cuts surrendered a cyclical windfall from the mining boom and have put the federal budget into structural deficit. According to work sourced from the National Centre for Social and Economic Modelling, the cuts amounted to a loss to Commonwealth revenue of almost $38 billion in 2011-12.

If those cuts had been reversed, health costs would have taken just 22.4% of tax revenue – up 0.1% over eleven years. That is hardly a picture of an unsustainable blowout:

[8] AIHW, *Health expenditure Australia 2011-12: Analysis by sector,* Canberra May 2014.

Table 2: Comparison of Commonwealth health funding with tax revenue (constant prices) assuming reversal of 'mining boom' tax cuts

Year	*Commonwealth health spending ($m)*	*Growth 2001-12 (%)*	*Commonwealth tax revenue ($m)*	*Growth 2001-12 (%)*	*Ratio in 2011-12 (%)*
2001-02	27 549	-	123 738	-	22.3
2010-11	58 983	114	263 105	112.6	22.4

Source: NATSEM modelling

For the states and territories, though, the situation is very different. There, though tax receipts (including GST) have grown by 74.5% over the period, health costs – mainly for public hospitals – have risen by 161.1%. As a ratio of tax income, the states' health bill was 16.4% in 2001-02 but had soared to 24.5% by 2011-12:

Table 3: Comparison of state and territory health funding with tax revenue (constant prices) 2001-02 to 2011-12

Year	*State/territory health spending ($m)*	*Growth year on year (%)*	*State/territory tax revenue* ($m)*	*Growth year on year (%)*	*Ratio (%)*
2001-02	14 661	-	89 669	-	16.4
2002-03	16 780	14.4	94 824	5.7	17.7
2003-04	17 349	3.4	101 963	7.5	17.0
2004-05	19 426	12.0	107 304	5.2	18.1
2005-06	21 907	12.8	114 155	6.4	19.2
2006-07	24 485	11.8	121 921	6.8	20.1
2007-08	26 379	7.7	132 512	8.7	19.9
2008-09	28 493	8.0	134 199	1.3	21.2
2009-10	31 870	11.9	141 338	5.3	22.5
2010-11	34 490	8.2	149 995	6.1	23.0
2011-12	38 290	11.0	156 494	4.3	24.5
Over period		**161.1**		**74.5**	

**Includes GST. Source: AIHW.*

That is the main reason why public hospitals around the nation are struggling to provide patients with adequate care, and why health costs threaten – at state, not the Commonwealth, level – to crowd out all other areas of government activity. Cutting Commonwealth programs like Medicare, the Pharmaceutical Benefits Scheme or federal hospital funding will make matters worse, not better.

The funding burden being shirked by Canberra also falls on the shoulders of individual patients. In 2011-12, direct payments by patients to public and private hospitals accounted for $2.45 billion and is growing fast. It rose over the eleven years by much more than federal or state governments or private health insurers – 10.3% for patients, 7.2% for the states, 5.3% for insurers and 3.9% for Canberra.

The Medical Research Future Fund

The Medical Research Future Fund was to amass $20 million to provide, from its earnings, a pool of money for medical research. The money would come from new imposts (such as the Medicare co-payments) and diverted Commonwealth health payments.

In its Budget documents the government said the new fund would be 'the largest medical research fund in the world':

> By increasing investment in research, Australians will help tackle cancer, diabetes and other diseases for their fellow Australians.[9]

The Treasurer said:

> It may be an Australian who discovers better treatments and even cures for dementia, Alzheimer's, heart disease or cancer. If we start investing now, this new and historic commitment in medical research may well save your life, or that of your parents, or your child.[10]

The government also claimed the measure would save money in the long run:

> [The new fund will] support the sustainability of the health system into the future. Medical research has a key role in improving health outcomes while at the same time making our health system sustainable in the decades ahead.[11]

But the measure indicates a lack of understanding about how medical research, particularly basic research, works. Advances in the treatment of complex conditions like Alzheimer's disease, cardiovascular disease and the various cancers are almost never a matter of miraculous breakthrough cures but of dogged, incremental and often tiny steps. There will probably never be 'a cure' for cancer or heart disease: there are too many cancers and too many factors causing heart ailments.

Treatment of cancer has improved substantially in recent decades but new drugs are almost always limited to one form of cancer, and often to a sub-group of people within that population. Many individuals have had their cancer cured – but a general cancer 'cure' is, because of the massive variations in the various forms of cancer, most unlikely.

And an 'Australian' cure? Medical research works globally more than locally. A discovery made in one country is likely to be taken to its next stage by another group somewhere else. Australian companies and research groups can invent a new drug and sometimes do, though they are likely to draw heavily on basic research conducted elsewhere. But it's almost impossible for them to bring their invention to the market without giving it to a major overseas drug company which can take it through the immensely expensive process of clinical trial and regulatory approval by the myriad of agencies around the world.

Investment in using the tools we already have in health care provides immediate, direct and fairly certain benefits to the community. Investing in medical research is something we do, as a good global citizen, to benefit the whole of humanity: its benefits are indirect and uncertain. Taking money out of health care in order to put it into research is most unlikely to result in better health outcomes for Australians. As such, it seems to be a poorly considered and destructive policy initiative.

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9 Brian Loughnane et al, *Sustainable, world class health care,* (Budget fact sheet), Liberal Party of Australia, May 2014.

10 Sue Dunlevy, $20 billion medical research future fund could cure our most feared illnesses, *Daily Telegraph* (Sydney), 13 May 2014.

11 J Hockey, M Cormann, P Dutton, *Joint media release,* May 2014.

The Tasmanian situation

Good or bad policy, at both levels of government, interact; and the effect can be multiplied by that interaction. That is happening in Tasmania's case today.

Despite some marginal recent improvements, the Tasmanian public hospital system is the worst funded and least efficient in the nation. The state receives far more money per head for health in GST funding but spends less on health than any other jurisdiction. The Australian government is cutting Commonwealth funding, which will further impact on Tasmania's public hospital system. The state government is embarking on a major round of budget cuts which are likely to further weaken health care delivery. The Commonwealth cuts, though unwelcome, are not in themselves disastrous for the state. But they give the Tasmanian government political cover for its own cuts.

Demographics

Tasmania has the oldest, sickest and poorest population of any jurisdiction, with the probable exception of the Northern Territory. An indication of this is the very high –and costly – death rate.

Analysis of data from the Australian Bureau of Statistics (ABS) shows that in Tasmania, death rates are substantially higher than for the nation as a whole. Tasmania has 2.3% of the nation's people but about 3% of its deaths. This state experiences about 1,000 more deaths a year – one in every four or five of Tasmanian deaths – than would be the case if deaths were spread evenly around the nation according to each state's share of the Australian population.

Table 4: Death rates, Tasmania and Australia, 2010 to 2012

	2010	*2011*	*2012*
Australian deaths[(a)]	143,473	146,932	147,098
Tasmanian deaths[(b)]	4,269	4,245	4,459
2.3% of Aust deaths[(c)]	3,300	3,379	3,383
Tas deaths above population share (%)[(d)]	22.7	20.4	24.1
Tas deaths above population share (number)[(e)]	969	866	1,076

(a) Actual number of deaths in Australia.
(b) Actual number of deaths in Tasmania.
(c) Number of deaths that would be expected in Tasmania if deaths were spread evenly throughout Australia on the basis of population share.
(d) Percentage of deaths in Tasmania in excess population share.
(e) Actual deaths in Tasmania in excess of population share.
Source: ABS

The most recent ABS health survey gives, using 2010 data, further insights into where the burden falls. In Tasmania, the 969 'extra' deaths translate into an extra 4,484 potential years of life lost. The figures are boosted particularly by people dying from cancer (an extra 236 deaths), cardiovascular disease (373), endocrine and metabolic diseases including diabetes (98), mental and behavioural disorders (93) and respiratory diseases (74).

The most likely reason for Tasmania's high death rate is to be found in its demography, including the 'hollowing out' of the population, with people in their twenties and thirties leaving the state, and older people moving here. Population figures from the ABS (for the September 2013 quarter) tell the story.

Table 5: Population by age group, Tasmania, September 2013

15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
33,905	31,779	30,153	28,895	30,313	35,224	34,719	37,857	35,320	32,973	27,937	20,615	15,171

Source: ABS

Tasmania's population is ageing far faster than the nation as a whole. Over the past 20 years the average age of the state's population has moved from being in line with the national average to being substantially above it: Tasmania now has the oldest average population of any jurisdiction. Although there is no direct, simple demographic link between ageing and costs of health, the fact that Tasmania has a higher proportion of older than younger residents means a higher death rate is inevitable.

Table 6: Average (mean) population age, Australia by states and territories, 1002 and 2013

	NSW	Vic	Qld	WA	SA	Tas	NT	ACT	Aust
1992	35.26	35.07	34.27	33.72	36.06	34.86	27.92	31.49	34.82
2013	38.79	38.55	37.66	37.26	40.09	40.43	33.10	36.60	38.37

Source: ABS

Tasmanians also have poorer health than their interstate peers. Two key indicators are obesity and smoking rates, both of which can cause a range of serious and life-threatening conditions. Although obesity rates are no worse then the national average, the numbers of proportion of adults who smoke is the highest in the nation with the exception of the Northern Territory.

Table 7: Health indicators: obesity and smoking rates, Australia by states and territories, 2011-12

	NSW	Vic	Qld	WA	SA	Tas	NT	ACT	Aust
Obesity	28.0%	26.0%	30.9%	29.4%	29.4%	28.5%	27.1%	25.5%	28.3%
Smoking	15.8%	18.0%	18.6%	18.6%	17.9%	22.5%	24.4%	14.7%	17.5%

Source: ABS

Another indicator of poor population health, relative to the rest of the country, is life expectancy at birth: in Tasmania, 78.7 for males and 82.6 for females; in Australia as a whole, 79.9 for males and 84.3 for females. Regardless of the composition of the population in general, life expectancy at birth indicates Tasmanians start their lives with poorer survival prospects than other Australians.

Poor health is strongly associated with low levels of education and low income. On both measures Tasmania is the worst performing of all jurisdictions, with the lowest rates of secondary school completion and the lowest per capita average weekly incomes. Low income also means people are more likely to rely on public hospitals and Medicare bulk-billing services. In Tasmania, also, private hospitals concentrate overwhelmingly on maternity and elective surgery, with relatively little involvement in inpatient services for life-threatening conditions. Again, this puts still more pressure on the public system.

Table 8: Education and household income levels: Australia by states and territories

	NSW	Vic	Qld	WA	SA	Tas	NT	ACT	Aust
% year 12[(a)]	59.3%	62.6%	57.8%	57.5%	52.8%	41.8%	52.1%	77.8%	59.1%
Weekly income[(b)]	$1,906	$1,767	$1,805	$2,117	$1,589	$1,443	$2,184	$2,395	$1,847

(a) 2013
(b) 2011-12
Source: ABS

Using Australian and overseas data, I have estimated that the 'extra' deaths in this state, above its population share, cost the public hospital system $31 million in 2011-12.

Under-funding by state governments

Because some states are richer than others and find it easier to fund the services their people need, the Commonwealth Grants Commission adjusts GST payments so each state (assuming equal efficiency in all states) is more or less equally able to provide services such as hospital, schools, police and justice, roads and so on. Tasmania is a beneficiary of this process, known as horizontal fiscal equalisation: this state has 2.3% of Australia's population but gets about 3.5% of the national GST pool.

In making its calculations, the Grants Commission takes into account the effect of demographic factors on inpatient costs including the number of people over 65 and the number of people with lower socio-economic status but not other health risk-factors, such as smoking rates, blood pressure data and education levels. When assessing Tasmania's 'expense drivers' for admitted patient care, the Commission calculated 16.8% for 'age 65+' (against a national average of 14.2%) and 32.4% for 'low SES population' (national average 20.3%). While this goes at least most of the way toward recognising the inpatient costs of the state's high death rate, it may not be a complete calculation.

Nevertheless, it delivers more benefit to Tasmania than to any other jurisdiction except the Northern Territory – $163 per head of population, or a total of $84 million extra:

Table 9: Effect of the admitted patient services assessment on the distribution of GST, 2014-15

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
$ (million)	144	-502	-53	38	171	84	-118	236
$ per capita	19	-85	-11	14	101	163	-298	968

Source: Commonwealth Grants Commission

This ought to be enough to make up for most, if not all, of the burden of Tasmania's demography on inpatient costs in its public hospitals. Another category of relevance to demographic health costs is 'Community and Other Health Services', under which the Grants Commission allocates an additional $85 million to Tasmania (or $166 per head) to pay for higher-than-average state government's expenditure on the primary care, outpatients, prevention and early intervention services for which it is directly responsible.

In 2014-15, Tasmania will receive as part of the redistribution of the national GST pool an extra $169 million, in excess of its population share, to allow it to fund the additional health services demanded by the state's demographics: $84 million for admitted patient care and $85 million for state-controlled primary care, outpatient and other areas needing above-average resourcing. Together, these GST payments amount to $169 million, or $329 for every resident of Tasmania.

However, this additional money being given to Tasmania to fund health is not being used for this purpose. In both admitted patient care and overall state government health funding, Tasmania spends at or below the national average *per capita:*

Table 10: Average recurrent health expenditure per person ($), current prices, all sources, 2007-08 to 2011-12

Year	NSW	Vic	Qld	WA	SA	Tas	NT	Average
2007-08	4,652	4,571	4,581	4,690	4,889	**4,627**	6,000	**4,664**
2008-09	4,982	4,944	4,977	5,025	5,298	**4,971**	6,581	**5,028**
2009-10	5,260	5,302	5,329	5,141	5,608	**5,136**	6,556	**5,320**
2010-11	5,424	5,615	5,549	5,516	5,900	**5,570**	7,325	**5,580**
2011-12	5,711	5,849	5,916	5,758	6,258	**5,823**	8,512	**5,881**

Source: AIHW, Health expenditure Australia 2011-12. ACT data are not available.

When we look specifically at the direct contribution of state and local government (stripping out the Commonwealth contribution) a very similar pattern emerges:

Table 11: Recurrent health expenditure, state and local government sources, 2011-12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Total ($m)	9,400	6,629	7,374	4,142	3,068	**742**	897	927	**33,179**
Per capita ($)	1,294	1,187	1,631	1,731	1,862	**1,463**	2,417	3,984	**1,473**

Sources: AIHW, Health Expenditure Australia 2011-12; ABS, Population Estimates.

In 2014-15, the extra GST grant given to Tasmania specifically for health amounts to $346 for each Tasmanian resident. If the GST money had been spent as intended, the per-capita figures above would rise by a commensurate amount and in each case would be substantially higher than the national average.

When we look at the specific costs of inpatient care, the picture is again similar:

Table 12: Expenditure on admitted patient care ($m), public hospitals, all sources, 2010-11 to 2011-12

Year		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
2010-11	*Total ($m)*	8,079	6,409	5,085	2,626	2,073	**552**	491	404	**25,716**
2010-11	*Per capita ($)*	1,125	1,166	1,146	1,132	1,270	**1,082**	1,346	1,754	**1,160**
2011-12	*Total ($m)*	8,939	6,848	5,258	3,133	2,264	**627**	644	453	**28,167**
2011-12	*Per capita ($)*	1,231	1,227	1,164	1,310	1,375	**1,225**	1,735	1,947	**1,251**
2012-13	*Total ($m)*	9,334	7,067	5,247	3,465	2,295	**637**	637	485	**29,167**
2012-13	*Per capita ($)*	1,269	1,243	1,137	1,398	1,381	**1,243**	1,685	2,037	**1,272**

Sources: AIHW, Australian Hospital Statistics; ABS, Population Estimates

Not only has the state government failed to spend even the national average amount on health; it has over many years also siphoned off all of the extra money given to it by other states, through the Grants Commission, to treat the specific health needs of the Tasmanian population. This money appears to have gone instead to support the government's general budgetary position, which is already supported by separate GST allocations to make up for the state's relative inability to raise its own revenue, for non-health aspects of demography, and the general state of its economy.

As can be seen in Table 6, the main beneficiary jurisdictions from this measure are the Northern Territory, Tasmania and South Australia. Table 12 shows that admitted-care spending in both SA and the NT is higher than the national average by about the amount they receive in GST redistribution. That is not the case for Tasmania.

The consequences of this diversion of funding in Tasmania are serious. In 2011-12 the Australian Institute of Health and Welfare calculated the cost of treating the average Australian inpatient, weighted for complexity of condition, at $5,200. On that basis, the $84 million in GST allocation for admitted patient care to be received this financial year would treat over 16,000 people.

The extent of unmet demand for hospital and other health services is unknown but is substantial: the length of waiting lists for elective surgery and for specialist consultations reveal part of the picture. Because the state government has for so long failed to spend the money required to meet the specific needs of the population – and which has been made available to it through fiscal equalisation – appears to be a major driver of the growing levels of unmet demand, along with the relative cost-inefficiency of Tasmanian public hospitals.

Efficiency

At the same time, the state's hospitals are not using efficiently the money they are given.

The key measure of basic economic efficiency in a hospital system is the cost per casemix-adjusted separation: the most recent figures released by the AIHW are for 2011-12. They show the cost of the average hospital service, weighted for complexity. In nominal terms, Tasmania's figure has increased by 2% over the previous period but, when hospital price inflation is taken into account, is likely to have remained essentially unchanged.

In the previous year Tasmania was the most economically inefficient system; it is now the second-most inefficient, overtaken by the ACT, whose costs are driven by a single institution, the very expensive Canberra Hospital.

Table 13: Changes in cost per casemix-adjusted separation, 2010-11 to 2011-12

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2010-11	4 904	4 508	5 323	4 996	4 854	5 913	5 401	5 645	4 918
2011-12	5 280	4 693	5 246	5 733	5 251	6 033	6 384	6 017	5 204
Nominal +/-	+7.6%	+4.1%	-1.4%	+14.7%	+8.1%	+2.0%	+18.2%	+6.6%	+5.8%

Source: AIHW

For this one year, Tasmania has turned in a relatively better performance than most other states which, with the exception of Queensland, have become less efficient than they were before. But Tasmania's costs remain unacceptably high and will need to be reduced by around 15% to 20% to meet the Commonwealth's National Efficient Price on which federal funding is based. It is also worth noting that there have been a number of particular years in the past in which per-service costs have stabilised, only to resume their upward trend. It cannot be assumed, on the basis of one year's results, that Tasmania has begun a genuine and sustained journey towards efficiency.

The relative situation can be seen below in the results for 2010-11 and 2011-12:

Table 14: Cost ($) per casemix-adjusted separation (excluding depreciation) 2010-11

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

Source: AIHW

Table 15: Cost ($) per casemix-adjusted separation (excluding depreciation) 2011-12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Medical labour costs	1 185	975	1 177	1 407	1 237	**1 295**	1 417	1 299	1 163
Non-medical labour	2 490	2 443	2 707	2 729	2 373	**2 990**	3 328	2 969	2 564
Nursing	*1 320*	*1 271*	*1 338*	*1 323*	*1 396*	***1 460***	*1 857*	*1 788*	*1 336*
Other staff	*1 169*	*1 172*	*1 368*	*1 406*	*977*	***1 531***	*1 471*	*1 181*	*1 229*
Other recurrent costs	1 604	1 275	1 362	1 596	1 642	**1 747**	1 639	1 749	1 477
Total	**5 280**	**4 693**	**5 246**	**5 733**	**5 251**	**6 033**	**6 384**	**6 017**	**5 204**
Cf national average (%)	**+1.4%**	**-9.8%**	**+0.8%**	**+10.1%**	**+0.9%**	**+15.9%**	**+22.6%**	**+15.6%**	**na**
Cf Victoria (%)	**+12.5%**	**na**	**+11.8%**	**+22.1%**	**+11.9%**	**+28.5%**	**+36.0%**	**+28.2%**	**+10.9%**

Source: AIHW

Taking population into account, Tasmanian hospitals treat fewer patients, by a wide margin: 91.7 overnight separations per 1,000 population, compared with the average of 115.4. This is not because Tasmanians require less care: our population in fact requires more care and is more reliant on the public system. So these figures are likely to mask a very high, but largely undocumented, level of unmet demand. The story is the same for overnight and same-day patients.

Table 16: Overnight acute separations per 1 000 population,

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2010-11	114.5	111.3	103.8	111.4	118.7	92.2	128.2	189.4	112.0
2011-12	120.4	113.4	109.6	114.9	122.4	89.7	128.2	190.7	116.2
2012-13	121.3	107.7	112.0	114.4	122.5	91.7	122.9	188.6	115.4

Source: AIHW

Table 17: Same-day separations per 1 000 population, public hospitals,

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2010-11	171.6	244.0	225.0	249.5	190.1	89.3	144.8	329.3	212.3
2011-12	178.1	252.8	233.6	259.1	198.9	89.2	147.1	363.7	219.5
2012-13	182.5	238.6	242.6	268.0	204.3	n.p	n.p	n.p	220.9

Source: AIHW

The new Tasmanian Minister for Health is systematically addressing many of the system's efficiency issues. If he is successful, Tasmanian hospitals are likely to deliver far better value for money, and patient care will become safer. But cuts by the state Treasurer threaten to undermine this. If, as seems probable, the only benefit of hospital efficiency is to the government's budget,

there will be no improvement in care for patients and little improvement in hospital staff's working environment.

Martyn Goddard is an independent health policy analyst based in Hobart. He has been a member of the Australian National Council on AIDS and Related Diseases and its clinical subcommittee, was the first consumer member of the Pharmaceutical Benefits Advisory Committee, and was Health Policy Officer at the Australian Consumers' Association (Choice). He also undertook many policy development projects for the Commonwealth and for medical colleges. Before that he was a journalist and documentary maker, mostly at the ABC.