

**Submission
to the
Tasmanian Government's
Health Reform Process**

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Introduction and summary

Efficiency reform

The Green Paper outlines reforms which should have been made many years ago. As it points out, Tasmania has the least adequate public hospital system in the country with the worst outcomes. The thrust of the measures – transferring some services to safer and more cost-effective hospitals, putting greater emphasis on primary care, improved purchasing processes, clinical redesign and so on – can be expected to improve capacity, responsiveness and safety by reducing waste. The government is to be congratulated for this process.

But it will take far more than this to bring the Tasmanian health system up to the general national standard and more still to ensure the sustainability of the system into the future.

This submission, then, concerns itself not with what is in the Green Paper but tries to point out important gaps. Unless these gaps are addressed, the government will not achieve its aims and the electorate will continue to be both disappointed and angry.

Demography

The particular demographic composition of the Tasmanian population, and the health needs that follow, must be at the centre of planning and funding. The detail of this composition is covered in the body of this submission. Briefly, this state's population is significantly more likely than the average of other states to have chronic illness, to need more complex interventions and to rely more heavily on the public system.

Tasmania also has a far higher death rate than other states. I estimate the cost to the hospital system of treating these 'extra' deaths in the last two years of life as being in excess of \$30 million a year; the cost of treating all deaths in the last two years of life is likely to be around \$130 million.

The state has a 'hollowed-out' population: many people tend to leave during their most productive years and return, or are replaced by others, at a later stage of life. Tasmanians also have far lower education standards, higher smoking rates and lower household income.

They do not, though, have higher levels of morbid obesity. The Green Paper errs, I believe, in quoting a figure for overweight rather than for obesity. Mere overweight does not produce substantial levels of illness and death; obesity does.

Funding and sustainability

Funding is the great gap in the Green Paper's discussion of sustainability. Efficiency alone will not ensure a high-quality and accessible health system is able to continue in the longer term. No state has the financial resources to meet its fast-growing health obligations, though the Commonwealth does. Unless the federal government becomes the increasingly dominant funder of public hospitals, the system in all states will eventually collapse, taking with it the fiscal stability of all state and territory governments.

But there are things the state can do. Better efficiency is certainly one of them. It could bring its

own funding up to the *per capita* level of other states. And, more importantly, the government could stop siphoning off the GST money – \$169 million this fiscal year – which is taken away from other states by the Commonwealth Grants Commission and given to Tasmania in recognition of the special health needs of Tasmanians. This money alone would boost state health funding by at least one-fifth and would solve many of our most acute health care problems. To continue to take this money away from the health sector would be unconscionable. The loss of this money is costing lives.

Tasmanians also receive less overall health funding than Australians in any other state or territory and fewer Medicare services – including GP consultations – than other states, despite clearly needing more than any of them. This under-use of both GPs and specialists needs urgent attention: after all, people who don't go to the doctor when they need to may end up in hospital.

On the other hand, Tasmanians fill more PBS prescriptions *per capita* than people in other states, which is to be expected in a population with higher levels of chronic and complex illness. What these apparently contradictory statistics mean also needs examination.

Individuals, either through direct payment for services or through insurance premiums, are required to pay far more than other Australians, despite their lower general capacity to do so.

Procurement processes for drugs and supplies need major reform. Tasmania's costs in these areas are far higher than in other states: the probable cause is the poor buying power of a small purchaser. No state has the purchasing power that two or more could bring to bear, so all have an interest in combining on this matter to force better deals from manufacturers. This is discussed in detail in this submission.

Procurement

This has been discussed publicly a number of times, and it is reassuring to see it mentioned in the Green Paper. No recent comparative national data is available because the Australian Institute of Health and Welfare did not release last year its analysis of the costs per weighted separation for admitted patient care.

For many years, though, the per-patient costs of drugs and supplies in this state have been massively higher than in other states. The previous government, and the Department, attempted to explain this in budget estimates hearings as being a matter of ‘clinical practice’ – doctors using too many drugs or using them wrongly – rather than purchasing cost.¹ If this was true, it would constitute a major scandal of inappropriate prescribing with a high probability of patient harm. There is no evidence that this is so.

By forming a procurement coalition, Tasmanian and Victorian hospitals could use their combined buying power that neither state could achieve on its own. The savings to be obtained for Tasmania are illustrated by the per-separation cost of drugs and medical supplies in this state, compared with other states and particularly with Victoria.

Table 1: Cost per casemix-adjusted separation of drugs and medical supplies (\$) in Australian public hospitals, 2009-10 and 2010-11

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Med/surg supplies (2009-10)	480	395	546	309	316	686	419	385	441
Med/surg supplies (2010-11)	540	390	582	332	335	780	467	414	471
Drug supplies (2009-10)	241	265	251	256	227	357	134	239	251
Drug supplies (2010-11)	254	239	257	267	238	317	144	243	250

Source: AIHW, Australian Hospital Statistics, 2009-10 and 2010-11

In 2010-11, Victoria spent on drugs 24.6% less per patient service than Tasmania (on a casemix-weighted basis) and half as much on medical and surgical supplies. Applying these figures to actual expenditure data yields a theoretical saving of \$11.790 million for drugs and \$59.026 million for supplies, giving a total of \$70.816 million.²

Table 2: Public hospital drug and supply expenditure (\$'000) in Victoria and Tasmania, 2010-11, and potential savings for Tasmania in reducing costs to those of Victoria

	<i>Victoria</i>	<i>Tasmania</i>	<i>Vic is less than Tas by</i>	<i>Potential Tas savings</i>
Drugs	495 231	47 928	24.6%	11 790
Med/surg supplies	807 654	118 052	50%	59 026
Total	1 302 885	165 980	-	70 816

Source: AIHW, Australian Hospital Statistics, 2010-11

In reality, savings of this magnitude would not be possible without significant market reform. The fragmentation – and therefore weakness – of the buyer side of the market means both states are likely to be paying far too much in most cases for these items. Reform of the market, to increase the

1 Michael Pervan, Estimates Committee A (Michelle O’Byrne) – Part 2, *Hansard*, Tuesday 4 June 2013, Parliament of Tasmania.

2 This assumes that patients with a given condition are given similar clinical treatment in both states, with similar drugs and supplies being used. In an era of internationally accepted standards of care and therapeutic guidelines, this assumption is probably reasonable.

mutual buying power of both states, and then to use that new power to enforce changes which would balance more equitably the position of buyer and seller, is the subject of these notes.

Such an outcome is not achievable by Tasmania on its own: it does not have the strength to change the structures of the markets in which it operates. Suppliers could too easily threaten not to supply Tasmania unless their demands were met: their businesses would not suffer unduly by doing so. They would be far more reluctant to take such an attitude with Tasmania and Victoria combined.

For Victoria, savings as a result of market reform of even 10%, plausibly achievable in the relatively short term, would on the basis of 2010-11 figures yield about \$130 million a year and, assuming normal price inflation, well over \$520 million across a four-year budget period.

Too often, manufacturers and wholesalers have been able to fragment the buyer side of their markets by a number of strategies. These include:

- Forcing hospitals and health departments to deal only with state-based middlemen rather than negotiating with the principal party – the manufacturer or importer. The principal company sets the wholesale price to the local middleman, who can then only reduce the price paid by hospitals by taking a lower retail margin.
- The practice of local hospital networks in dealing separately with suppliers, rather than teaming up together, massively undermines their power to negotiate.
- Marketers will often offer structured price reductions – known as price volume agreements – on the basis of how many units a particular user will buy. Some of the larger hospital networks may believe that, through this system, they are getting a good price. They are almost certainly wrong in this comfortable assumption. They are getting a good price only in relation to other, smaller institutions and networks but a poor result compared to that which a less fragmented system would yield.

At the Commonwealth level, the Pharmaceutical Benefits Scheme always negotiates price with drug manufacturers: eventual users (such as individuals in the case of the main list or hospitals in the case of the Highly Specialised Drugs Program list) order as they want from retail pharmacies or wholesale suppliers. This system is well-tried and the industry is accustomed to it. It could readily be extended to other areas, such as therapeutic devices and certain diagnostics.

In the case of manufacturers who refuse to comply with this well-tried system, the relevant products should be de-listed whenever this does not involve a substantial clinical penalty for patients.

Where feasible, generic items should be supplied subject to open tender. Generic manufacturers compete energetically on price, particularly when several rival companies are marketing the same compound: the most efficient way of making use of this competition is through a tender process. The large makers of patent drugs, on the other hand, operate as a pricing cartel even when their products are clinically interchangeable. Tenders will not work in this environment: individual negotiations with manufacturers must therefore take place.

There is no reason why this initiative should add to bureaucracy levels. A joint committee between the two states with official and expert membership should oversee the lists. Negotiations with suppliers should be undertaken by officials in their current positions.

The listings committee should include, apart from officials, at least one clinical pharmacologist, at least one surgeon, at least one pathologist, microbiologist or virologist, a health economist with knowledge of procurement policy, and a representative of the consumer's viewpoint. Expert members should be chosen for the particular knowledge, experience and insight they can bring to the table. They should specifically *not* represent any organisation or sectional interest and should not be chosen because they do. A panel of clinical and technical experts, independent of industry,

should be established whose individual members can be called upon to assist consideration of particular items. The independence of all members of the main committee and its consultative panel is essential to the integrity of the process. For the same reason, manufacturers and suppliers should not be represented.

Sustainability

The cost of health to all state and territory governments clearly cannot be sustained in the longer term and there is very little their governments can do about it. Our health system can indeed be sustained but this depends on Commonwealth actions. Efficiency drives at state level, though necessary, will have little long-term effect on the tendency of health costs to overwhelm state budgets.

The most relevant way of looking at the capacity of the Commonwealth and the states to pay for the health system is the ratio of health expenditure to taxation income for each level of government, rather than at the actual amount spent. The Australian government has frequently pointed to the increasing dollar cost of health, and indeed it has more than doubled in ten years. But its taxation income – its capacity to pay – has risen by almost as much. The ratio of the Commonwealth's health expenditure to tax income went from 21.4% to 24.8% over the decade – a significant rise but a manageable one.

Calculations by the National Centre for Social and Economic Modelling at the University of Canberra showed that this 3.4% rise was the result not of the increase in health spending but of a decline in government revenue. This was the result of temporary proceeds of the mining boom in the period 2004 to 2007 being relinquished in the form of permanent tax cuts. NATSEM calculated that in 2001 these tax cuts would have been worth \$37.6 billion to the federal budget.³ If that revenue had still been available to the government, the ratio of health costs to income would not have risen at all.

A very different situation faces the states and territories. Their health expenditure rose much faster than the Commonwealth's, by almost two and a half times. But their taxation income rose by only 1.7 times. The result was a ratio which rose from 17.7% in 2002-03 to 24.5% ten years later.

Despite the federal government's claims to the contrary, its health expenditure is entirely sustainable. That of the states and territories is not.

**Table 3: Ratio of government spending on health to tax income, current prices
2002-03 to 2012-13**

<i>Year</i>	<i>C'/wlth health funding (\$m)</i>	<i>States health funding (\$m)</i>	<i>C'/wlth tax revenue (\$m)</i>	<i>States tax revenue (\$m)</i>	<i>Ratio C'/wlth (%)</i>	<i>Ratio states (%)</i>
2002-03	29 833	16 780	139 109	94 744	21.4	17.7
2003-04	31 841	17 349	150 685	102 006	21.1	17.0
2004-05	35 268	19 426	166 512	107 677	21.1	18.0
2005-06	36 812	21 907	178 264	114 598	20.6	19.1
2006-07	39 572	24 485	192 566	122 136	20.5	20.0
2007-08	44 473	26 379	209 033	132 687	21.2	19.8
2008-09	49 678	28 493	198 541	134 350	25.0	21.2
2009-10	52 536	31 870	183 176	141 517	28.6	22.5
2012-11	56 201	34 490	200 876	150 196	27.9	22.9
2011-12	60 551	38 224	224 832	156 677	26.9	24.3
2012-13	60 601	39 767	244 355	161 887	24.8	24.5

GST is counted as a state tax.

Source: AIHW, Health Expenditure Australia 2012-13: analysis by sector

Only the Commonwealth has the revenue-raising capacity to support the health system – including

³ M Grudnoff, *Tax cuts that broke the budget: policy brief 51*, Australia Institute, Canberra, May 2013.

public hospitals – in the long term. Efficiencies at state level are entirely necessary but will not solve the underlying imbalance of supply and demand. Some other states, most notably Victoria, have successfully pursued efficiencies and savings for decades but the condition of that state's public hospitals still falls far short of what the people believe they have the right to expect. Being a health minister in Victoria or New South Wales is no easier than it is here.

From the Tasmanian government's point of view, the political danger lies in the community's expectation that the necessary reforms currently under way will fix the system: radically shorten waiting lists, end ambulance ramping and bed block, and bring Tasmanian performance standards up to those of the rest of the nation.

But without attention to the other aspect of the problem – overall under-funding, even compared to other states – these outcomes, demanded and now expected by the electorate, will not happen.

Here's why:

- This fiscal year, \$169 million is being given to Tasmania in GST funding in recognition of the special health needs of our older, sicker, poorer population. But none of that money will go to health. We have been getting that money for many years but it has not gone into the health budget; instead, it has been used to fund other areas of government activity.
- This has had two effects: it has reduced the capacity of our hospitals far below the levels of their interstate peers and it has built up, over time, a substantial but unquantifiable number of under-treated or untreated people. If those people are given hope that the public system may at last deal with them, many are likely to come forward. If that happens it is entirely possible that waiting lists could remain as they are or even lengthen, particularly for less-urgent surgical and medical conditions.
- On top of this, the state's contribution both to public hospitals and to the broad health system has been less, *per capita*, than the national average.
- As we have seen, no state has the financial resources to fund its health responsibilities. As time goes on, this situation will become more and more critical and no amount of increased efficiency can change the eventual outcome. Unless the Commonwealth either gives the states the financial resources to do their job, or takes over responsibility for a majority of hospital funding, the public hospital system as we know it will collapse and will take with it the financial stability of all state governments.

Demographics

Tasmania's demographic – an older, poorer, sicker population than in other jurisdictions – is the main driver of this state's need not only for health and hospital services but for *publicly funded* services. Low income, age and chronic disease, which are often found together in the same person, combine to increase illness and to decrease capability of people funding their own care.

One element of this demographic is the 'hollowing out' of the population, with people in their twenties and thirties leaving the state, and older people moving here. Population estimates from the Australian Bureau of Statistics tell the story.

Table 4: 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 population estimates

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 5: Average (mean) population age, Australia by states and territories, 1992 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 population estimates

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 than 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 6: 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 health survey

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 7: Education and household income levels: Australia by states and territories

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>NT</i>	<i>ACT</i>	<i>Aust</i>
% 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

Tasmania's higher death rate

Tasmania's demographics also produce a high death rate, relative to population size. Various Australian and overseas studies have calculated that between 10% and 33% of a patient's lifetime health costs accrue in the last year of life. Together, these studies support an estimate of about 25% for both hospital and for broad health system costs.

Therefore, the rate at which deaths occur in a community has major implications for the costs of its health system. 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 8: Deaths, Australia and Tasmania, 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 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).

Because the one to two years immediately preceding a person's death are so costly to the health and

hospital systems, it is important to know how much Tasmania's high death rate is costing, relative to the rest of the country.

As we have seen, if deaths were distributed throughout the nation in the same proportion as the population as a whole, Tasmania in 2012 would have experienced 1,076 fewer deaths than it did.

Many studies in a number of countries have shown, though with divergent results, the extraordinarily high cost of the last few months of life. In the United States, people over 65 dying of heart failure in 2007 were found to have incurred hospital costs of \$US36,000 in the last six months of their lives.⁴ In Canada, similar patients incurred \$C28,000 in the last six months.⁵ The very high cost of care in the US may explain at least part of this difference: the Canadian experience is likely to be more comparable with Australia's.

A literature survey by Australia's Productivity Commission found American Medicare patient hospital costs for the last year of life were on average six to seven times greater than the annual costs of other over-65 patients. In Denmark, this ratio was higher – for men, 13.3 times than for other patients and for women 9.4 times.⁶

A New Zealand study, drawing on data from 2007 to 2009, calculated broad health expenditure (including outpatient, pharmaceutical and primary care interventions as well as inpatient costs) as 10-fold higher in the last six months of life than for patients who did not die, peaking at over \$NZ30,000 for people aged 80 or more.⁷

Few Australian studies have investigated the costs of dying to the hospital system and only one has calculated a firm dollar figure. A study of patients over 65 who died in New South Wales in 2002 and 2003 found (in common with most other studies) that hospital costs associated with dying decreased with the age of death, most probably because older people were treated less aggressively by doctors and were more likely to die in nursing homes than in hospital. There is little evidence of costs associated with people under 65 but here, too, cost is likely to be inversely proportional to age. Young people are disproportionately likely to die as a result of injury, which involves more costly treatment than most illnesses; and doctors are likely to treat young people more aggressively in an attempt to save their lives.

The NSW study calculated the inpatient costs of people in the last year of life at \$13,513 for all people over 65. This study, along with others, shows that inpatient costs incurred in the second-last year of life were about one-third of those in the final year: on the basis of 2002-03 data, taking this into account would produce a figure of \$17,972 for each patient in the final two years of life.⁸

Hospital costs have risen substantially since 2002-03, the period for which these figures were current. The national average cost of each casemix-adjusted separation (that is, for each episode of inpatient case weighted for complexity) went from \$3,184 in 2002-03 to \$5,204 in 2011-12. Applying this proportional rise to the overall figure in the NSW study gives a result of \$29,369 for 2011-12. Because this does not take into account the costs of care for people under 65, and because hospital costs generally are higher in Tasmania than in the rest of the nation, this is likely to be a conservative estimate.

4 Kathleen T Unroe, Melissa A Greiner et al, Resource use in the last 6 months of life among Medicare beneficiaries with heart failure, 2000-2007, *Archives of Internal Medicine*, vol 171, pp 196-203, 11 October 2010.

5 Anne Harding, *End-of-life care costs continue to climb upwards*, Reuters Health, New York 14 October 2010.

6 Productivity Commission, *Costs of death and health expenditure*, Technical paper 13, Productivity Commission, Canberra, April 2005.

7 Tony Blakely, June Anderson, et al, Health system costs by sex, age and proximity to death, and implications for estimation of future expenditure. *New Zealand Medical Journal*, vol 127, no. 1393, 2 May 2014.

8 Katina Kardamanidis, Kim Lim et al, Hospital costs of older people in New South Wales in the last year of life, *Medical Journal of Australia*, vol 187, no 7, pp 383-386, 1 October 2007.

**Table 9: Estimated inpatient costs incurred in the last
two years of life, Tasmania, 2009-10 to 2011-12**

	<i>2009-10</i>	<i>2010-11</i>	<i>2011-12</i>
Total Tasmanian deaths	4,269	4,245	4,459
Cost per death (\$)	26,562	27,758	29,369
Cost of all Tasmanian deaths (\$)	113,393,178	117,832,710	130,956,371
'Extra' Tasmanian deaths	969	866	1,076
Cost of 'extra' Tas deaths (\$)	25,738,578	24,038,428	31,601,044

Deaths in excess of the number which would be expected from Tasmania's overall population share are estimated to cost the state's hospitals \$31.6 million a year in terms of inpatient care in the last two years of life. This amount represents a load specifically falling on Tasmania and its hospital system, and which is not felt by the rest of the nation.

The total cost of treating all inpatients during the last two years of life is estimated to amount to \$131 million annually.

Funding

Because the health needs of Tasmanians are so much greater than those of people in other states, it would be expected that funding in this state would also be greater, on a per capita basis, than elsewhere. In fact, the opposite is true. The Green Paper recognises this but does not analyse the extent and composition of the shortfall.

Generally, Commonwealth funding for public hospitals and for the overall health system is in line with other states. But state government funding, though volatile, is substantially less than that of its peers.

Table 10: Per capita health funding (\$) by source, states and territories, 2012-13

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Average</i>
Aust govt	2,765	2,650	2,604	2,265	2,718	2,792	2,557	2,785	2,644
State/local	1,529	1,349	2,036	2,158	1,986	1,275	2,852	4,567	1,735
Non-govt^(a)	2,100	2,256	1,882	1,992	1,783	2,207	1,811	1,508	2,051
Total	6,394	6,255	6,522	6,415	6,487	6,274	7,220	8,860	6,430

(a) Includes funding from private insurers, out-of-pocket expenses paid by individuals and injury compensation insurers.

Source: AIHW, Health Expenditure Australia 2012-13: analysis by sector.

Three points immediately emerge from Table 10:

- Tasmanians receive less overall health funding than Australians in any other state or territory with the exception of Victoria;
- The Tasmanian government contributes far less than its peers;
- Individuals, either through direct payment for services or through insurance premiums, are required to pay far more.

This pattern is repeated when we look specifically at funding for public hospitals:

Table 11: Per capita public hospital funding (\$) by source, states and territories, 2012-13

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Average</i>
Aust govt	731	706	671	656	736	904 ^(a)	681	768	709
State	962	989	987	1,110	1,239	852	1,734	2,129	1,032
Non-govt^(b)	196	165	197	149	132	84	61	80	173
Total	1,889	1,860	1,855	1,915	2,107	1,840	2,476	2,977	1,914

(a) The figure for this year was unusually high, probably as a result of capital grants. Previous years have been much closer to the national average. (b) Includes funding from private insurers, out-of-pocket expenses paid by individuals and injury compensation insurers.

Source: AIHW, Health Expenditure Australia 2012-13: analysis by sector.

Again, Tasmanian hospitals receive less money than those in other states, even though they need more than the average in order to meet the higher demands of our population. Again the state government is not pulling its weight. The 2012-13 figure for total funding is inflated by much higher-than-average Commonwealth funding, probably as a result of special grants such as those for the reconstruction of the Royal Hobart Hospital. The lower than average non-government funding can be attributed to the unusually low amount being received from people being treated as private patients and paying through their health insurance.

Going to the doctor

And in primary care, again the pattern of cost-shifting by the state is seen. Here, the shortfall has to be picked up by individuals, mostly through out-of-pocket expenses in addition to those demanded by the Pharmaceutical Benefits Scheme and co-payments charged by GPs.

Table 12: Per capita primary care funding (\$) by source, states and territories, 2012-13

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Aust govt	1,046	952	1,009	824	1,065	1,040	846	1,486	994
State/local	255	162	486	337	497	274	568	1,718	326
Non-govt^(a)	1,015	1,109	861	972	896	1,039	930	771	991
Total	2,316	2,223	2,356	2,133	2,458	2,353	2,344	3,975	2,311

(a) Includes funding from private insurers, out-of-pocket expenses paid by individuals and injury compensation insurers.

Source: AIHW, *Health Expenditure Australia 2012-13: analysis by sector*.

When we look at PBS funding, a key indicator of clinical need, we see that Tasmanians need more prescriptions on average than residents in any other state or territory: in 2013-14, 11.4 each against a national average of nine. And, despite being having the lowest incomes of any state, they obtain little relief from the complex safety-net arrangements put in place under the Howard government, when Tony Abbott was Health Minister: this conclusion is supported by other PBS data on the operation of the safety nets. Despite these measures, increased prescription volume translates into a greater financial load on individuals. In the last fiscal year Tasmanians paid more in PBS co-payments than people in any other state – \$75.81 against a national average of \$66.26. The figures in the following table refer to drugs on the main PBS list only, and do not include hospital drugs funded by the Commonwealth. This list is dominated by prescriptions made by general practitioners.

Table 13: Per capita PBS costs to Commonwealth and to patients (\$) and prescription volumes, states and territories, 2012-13 and 2013-14

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Govt cost 2012-13	329.1	307.2	296.6	258.8	355.9	375.2	236.1	107.1	308.6
Co-payments 2012-13	63.11	65.04	64.60	59.38	72.36	73.19	31.47	60.35	65.28
Govt cost 2013-14	334.6	312.9	296.8	263.2	356.9	398.9	240.1	113.2	312.7
Co-payments 2013-14	68.31	66.44	64.65	73.83	60.34	75.81	32.52	58.50	66.26
Volume 2012-13	9.1	8.8	8.4	6.8	10.1	10.7	5.7	2.8	8.6
Volume 2013-14	9.5	9.2	8.7	7.1	10.6	11.4	5.8	3.0	9.0

Main (Section 85) PBS list only.

Source: PBS statistics: *Expenditure and volume, 2013 and 2014*; ABS population estimates.

Despite the clear need for higher-than-average health care at all levels, statistics on Medicare attendances reveal a serious lack of access to doctors. Whether this is mainly a factor of doctor shortages or an inability to afford practitioners' co-payments is not clear from these data, though both may be involved. People in Tasmania use fewer Medicare-funded services than in any jurisdiction other than the Northern Territory: 14.17 services each in the last fiscal year, compared with 15.27 in the country as a whole. The overall dollar value of Medicare benefits also reflects this.

Tasmanians who do go to the doctor need more prescriptions, on average, than other Australian patients. This indicates that group accessing care is likely to be composed disproportionately of people with more complex or chronic conditions. The group who do not go to the doctor – or are

not going as often as elsewhere – is of concern. Research is urgently needed into who these people are, what their needs are and what additional services they require. But because in general there are far more patients in the community with lower acuity conditions than higher acuity, this under-treated cohort may be large. Some may be presenting to public hospital emergency departments; if that is happening more than in other states, it is also a problem.

Bulk-billing rates are a little lower than the national average: this is unwelcome news, because it would be expected and hoped that they would be higher, given the higher proportion of people with low incomes. Generally, though, practitioners seem to recognise the financial situation of their patients: while bulk-billing rates are comparatively low, Tasmanian patients are paying less than most others in co-payments to doctors. This appears to indicate that practitioners are spreading the costs of their practices more widely but more thinly across their patients.

Table 14: Medicare statistics, all services (except dental), states and territories, 2012-13 and 2013-14

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Services per capita 12-13	16.32	15.40	14.85	11.71	15.05	13.86	11.85	9.15	15.00
Services per capita 13-14	16.50	15.68	15.24	12.07	15.24	14.17	12.15	9.74	15.27
Benefits (\$) per capita 12-13	901.52	826.60	800.81	608.96	801.00	740.28	610.86	442.52	810.50
Benefits (\$) per capita 13-14	897.28	836.36	821.18	635.99	808.57	761.19	629.37	481.95	820.03
Bulk billed rate (%) 12-13	78.8	75.8	76.3	70.7	77.1	73.7	64.2	83.1	76.5
Bulk-billed rate (%) 13-14	79.2	76.6	77.2	72.1	77.9	74.4	65.5	85.4	77.2
Av cost to patient (\$) 12-13^(a)	52.27	47.24	46.55	48.05	40.40	37.54	50.57	57.12	48.12
Av cost to patient (\$) 13-14^(a)	56.02	50.76	49.77	52.33	42.75	40.03	59.35	53.73	51.61

(a) Out-of-pocket cost to patients who were not bulk-billed.

Source: Medicare statistics, 2014; ABS population estimates.

Drilling down further into the figures shows, though, that this effect – of more people paying co-payments but at a lower rate – is confined to specialist practices. In primary care (principally, general practice) patients are charged co-payments at about the same amount as the national average but bulk-billing rates in Tasmania are lower than anywhere except the ACT.

The following two tables, which examine primary care and specialist services separately, show the relatively low attendance rates persist both in general practice (and other primary services) and in specialist attendances outside of public hospitals.

Table 15: Medicare statistics, primary care services, states and territories, 2012-13 and 2013-14

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Services per capita 12-13	6.10	5.80	5.64	4.41	5.78	5.31	4.36	3.50	5.62
Services per capita 13-14	6.24	5.98	5.78	4.55	5.89	5.41	4.47	3.83	5.76
Benefits (\$) per capita 12-13	281.11	265.63	259.30	196.23	267.93	241.66	193.60	174.15	258.78
Benefits (\$) per capita 13-14	293.49	279.59	273.26	209.43	280.66	251.07	201.98	193.75	271.69
Bulk billed rate (%) 12-13	86.8	82.1	81.7	73.0	81.4	76.4	55.0	78.2	82.2
Bulk-billed rate (%) 13-14	87.7	83.2	82.9	75.5	82.5	77.3	57.1	81.5	83.4
Av cost to patient (\$) 12-13^(a)	28.27	28.92	29.86	31.52	25.48	29.60	34.69	38.30	29.32
Av cost to patient (\$) 13-14^(a)	30.12	30.54	31.45	33.52	26.87	31.65	36.18	40.08	31.03

This table does not include specialist services such as specialist doctors, pathology and imaging.

(a) Out-of-pocket cost to patients who were not bulk-billed.

Source: Medicare statistics, 2014; ABS population estimates.

The low figures for primary care may, in part, be explained by Tasmania's lower numbers of general practitioners. Recent research has shown that lower numbers of GPs, and the consequent lessening of competition, is associated with lower rates of bulk billing.⁹

AIHW workforce figures show the numbers of full-time equivalent doctors as a proportion of the population is lower in Tasmania than in any jurisdiction other than Western Australia:

Table 16: Full-time equivalent employed medical practitioners per 100,000 population, states and territories, 2012

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
378.3	366.5	373.2	343.9	400.9	359.1	456.3	466.6	374.0

Source: AIHW, Medical workforce 2012

The figures for specialist attendances (Table 17) confirm that Tasmanian specialists are only a little more likely than their interstate peers to bulk-bill their patients (bulk-billing rates are low everywhere), the co-payments they demand above the Medicare rebate were substantially less. This seems to indicate that specialists recognise the relative inability of Tasmanian patients to meet very high out-of-pocket costs: if so, it is perhaps a recognition of what the market in this state will stand.

Table 17: Medicare statistics, specialist attendances, states and territories, 2012-13 and 2013-14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Services per capita 12-13	1.29	1.29	1.04	0.80	1.24	1.11	0.83	0.40	1.16
Services per capita 13-14	1.32	1.33	1.08	0.81	1.24	1.11	0.86	0.39	1.19
Benefits (\$) per capita 12-13	99.70	96.34	75.36	56.62	88.50	73.58	62.92	27.92	86.55
Benefits (\$) per capita 13-14	103.91	100.52	79.61	58.30	89.43	75.70	67.06	27.82	90.12
Bulk billed rate (%) 12-13	33.4	28.0	23.2	16.5	33.7	28.9	23.9	47.9	28.7
Bulk-billed rate (%) 13-14	33.7	28.7	24.3	16.8	33.6	29.7	26.0	48.8	29.2
Av cost to patient (\$) 12-13^(a)	62.79	52.20	58.29	56.39	44.75	44.96	69.61	66.95	57.03
Av cost to patient (\$) 13-14^(a)	66.79	56.10	62.37	61.42	47.91	48.42	74.42	73.42	61.11

(a) Out-of-pocket cost to patients who were not bulk-billed.

Source: Medicare statistics, 2014; ABS population estimates.

⁹ R D Lourenco, Kennedy P, Haas M R, Hall J P, Factors affecting general practitioner charges and Medicare bulk-billing: Results of a survey of Australian, *Medical Journal of Australia*, vol 202, no 2, pp 87-91, 2 February 2015.

Health and the GST

The effect of GST redistribution on state health funding is of immense significance but is largely ignored in political and media discussion. Commonwealth grants for specific purposes, such as health and education, are required by intergovernmental agreements to be distributed between the states and territories on a population basis. These grants are not designed to make up the differences between the states in raising their own revenue or in meeting special population needs. That is the job of the GST and the Commonwealth Grants Commission.

The Commission's calculations are done in two broad stages. The first ironing out the most basic differences between rich and poor states. Some find it easier to raise the money they need from their own resources: Tasmania finds it particularly hard, and only about one-third of the state government's budget comes from its own taxes, charges and transactions. So the Commission adjusts GST payments so that each state (assuming equal efficiency everywhere) has an equal amount of cash per head.

**Table 18: Stage 1 of GST redistribution:
Budget effect of equalisation of government revenue, per capita, 2014-15**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Payroll tax	-21	40	45	-332	217	335	27	119
Land tax	4	-16	-3	-97	107	154	122	90
Stamp duty	-64	-41	88	-54	189	243	-90	112
Insurance tax	-14	7	6	7	-6	37	10	25
Motor tax	47	-9	-18	-93	3	-10	59	28
Mining revenue	262	455	-139	-1,825	280	353	472	-50
TOTAL	214	436	-21	-2,394	790	1,112	600	324

Source: Commonwealth Grants Commission.

If all states populations were homogeneous, with exactly the same needs, the Commission could stop its assessment process there. But they are not, and the second stage considers specific population needs across the range of state government services.

In health, it takes into account the effect of demographic factors on 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%).

In health, this process delivers more benefit to Tasmania than to any other jurisdiction except the Northern Territory – \$329 per head of population, or a total of \$169 million extra, composed of \$84 million for admitted patient care and \$85 million for other health services including outpatients, community clinics and prevention.

**Table 19: Stage 2 of GST redistribution:
Budget effect of assessment of specific population needs, per capita, 2014-15**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
<i>School education</i>	0	-168	91	94	-53	191	-136	1,428
<i>Tertiary education</i>	-6	-12	-2	25	-9	2	98	139
<i>Admitted patients</i>	19	-85	-11	14	101	163	-298	968
<i>Non-admitted health</i>	-106	-53	11	251	-36	166	272	1,118
<i>Welfare & housing</i>	-12	-91	23	-24	101	230	-196	1,498
<i>Community services</i>	-38	-66	23	104	-15	-61	-43	1408
<i>Justice</i>	-20	-116	27	92	-22	84	-16	1,897
<i>Roads</i>	-39	-45	28	104	44	-21	-104	542
<i>Transport</i>	19	24	-20	1	-42	-123	-62	-127
<i>Industry services</i>	-11	-11	-4	23	24	60	14	134
<i>Depreciation</i>	-23	-49	18	72	18	15	-74	729
<i>Other expenses</i>	-28	-36	17	19	-38	128	333	655
<i>Investment expenses</i>	-61	-49	44	268	-106	-190	-15	454
<i>Borrowing/lending</i>	-14	0	9	48	-24	-41	-16	-9
TOTAL	-320	-757	254	1091	-27	603	-281	10 834

Source: Commonwealth Grants Commission.

Does the state government spend this extra money on health and hospitals?

No. As we have seen, Tasmania will receive as part of the redistribution of the national GST pool in 2014-15 an extra \$169 million to allow it to fund the additional health services demanded by the state's demographics. But this money goes nowhere near health. Instead, it is funnelled off by the state Treasury into consolidated revenue where it is used to pay for many other aspects of government activity – but not health.

If that money – \$329 per head – was being used for the purpose intended by the Grants Commission, Tasmania's per capita health expenditure would be commensurately higher than the national average. But it is not. In fact, as we have seen in Tables 10, 11 and 12 earlier in this submission, in both admitted patient care and in overall state government health funding, Tasmania spends at or below the national average.

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.